Minutes of the meeting of the Audit and Compliance Committee of the Board of Directors of the Cook County Health and Hospitals System held Thursday, February 19, 2015 at the hour of 8:30 A.M. at 1900 W. Polk Street, in the Second Floor Conference Room, Chicago, Illinois.

I. Attendance/Call to Order

Chairman Velasquez called the meeting to order.

Present: Chairman Carmen Velasquez and Directors Emilie N. Junge and Ada Mary Gugenheim

Present
Telephonically: Board Chairman M. Hill Hammock (ex-officio)

Absent: None (0)

Director Gugenheim, seconded by Director Junge, moved to allow Board Chairman Hammock to participate in the meeting telephonically. THE MOTION CARRIED UNANIMOUSLY.

Additional attendees and/or presenters were:

Cathy Bodnar – Chief Corporate Compliance and Privacy Officer
Elizabeth Reidy – General Counsel
Deborah Santana – Secretary to the Board
Tom Schroeder – Director of Internal Audit
John Jay Shannon, MD –Chief Executive Officer

II. Public Speakers

Chairman Velasquez asked the Secretary to call upon the registered public speakers.

The Secretary responded that there were none present.

III. Director of Internal Audit – Information and Action Items

For information:

A. Report from Internal Audit – review of information on CCHHS Internal Audit Function (Attachment #1)

Tom Schroeder, Director of Internal Audit, provided an overview of the Report from Internal Audit. The Committee reviewed and discussed the information.

During the review of the information, Mr. Schroeder noted that activities will begin for the 2014 audit by the external auditors in early March; he expects that representatives from McGladrey LLP will be present at the March Committee Meeting to provide an overview of their plan and update on their activities.

III. Director of Internal Audit – Information and Action Items (continued)

The Committee discussed the relationships and responsibilities between Internal Audit, Corporate Compliance and the County's Office of the Independent Inspector General (OIIG). In response to a question regarding reports issued by the OIIG, Dr. John Jay Shannon, Chief Executive Officer, stated that he has had conversations on that subject this week about figuring out the appropriate way to organize and concurrently make the Board aware of anything that comes out from the OIIG related to the System. When the OIIG does an inspection of any bureau or department of the County, typically the person who is in charge of that area receives the report; in the case of the System, Dr. Shannon receives it. Those who also receive the report are the general counsel for that area and the President. He and Elizabeth Reidy, General Counsel, are working on a procedure by which they can sum and feed into the Board the appropriate part; in the initial discussions on the subject, it was felt that the Audit and Compliance Committee is the appropriate place to funnel up that information to the rest of the organization.

Dr. Shannon provided comments with regard to the subject of Committee metrics relating to Internal Audit. He stated that he supports the Board's drive to make the organization responsible and make that accountability with an ongoing set of metrics; however, one area that is difficult to measure in the same kind of cold, quantifiable way is Internal Audit; an exception to that is perhaps relating to measuring progress in addressing deficiencies identified in the external audit by McGladrey LLP. He and Mr. Schroeder plan to further work on addressing the subject. Board Chairman Hammock indicated that he looks forward to seeing what can be done.

For approval:

B. Internal Audit Charter (Attachment #2)

Director Gugenheim, seconded by Director Junge, moved to approve the Internal Audit Charter. THE MOTION CARRIED UNANIMOUSLY.

C. Charter for Audit and Compliance Committee – review as it relates to Internal Audit and Corporate Compliance (Attachment #3)

Mr. Schroeder and Cathy Bodnar, Chief Corporate Compliance and Privacy Officer, reviewed the information presented regarding the Charter for the Audit and Compliance Committee.

In response to a question from Board Chairman Hammock regarding whether the subject of technology systems is highlighted in the Charter, Mr. Schroeder responded in the negative; however, he stated that Internal Audit annually conducts a risk assessment on a formal basis. Following discussion, it was determined that the Charter would be amended to include that subject and brought back to the Committee at the next meeting for consideration and approval.

Board Chairman Hammock referenced the section in the Charter regarding the Committee Chair's right to hold executive closed sessions to review and discuss matters. He stated that it is his experience that it is best practice to hold very regular executive closed sessions where only Committee Members or Board Members are in attendance; no staff members are in attendance. He proposed that it become a formal practice that, at least quarterly, an executive closed session be held with the entire Board, led by the Committee Chair. When it is time for the Committee's quarterly focus area presentation to the Board, he suggested that it be made a part of that which is held in closed session. Mr. Schroeder indicated that this can be memorialized in the Charter.

Following the discussion, Mr. Schroeder stated that updates will be made to the Charter and presented for approval at the next Committee Meeting.

IV. Corporate Compliance and Privacy Officer – Information and Action Items (Attachment #4)

Ms. Bodnar provided an overview of the presentation on the Information and Action Items relating to Corporate Compliance. The Committee reviewed and discussed the matters.

For approval:

A. CCHHS Compliance Program Operations Plan (Attachment #5)

Following discussion, a minor amendment was made to the Plan on page 4.

> Director Gugenheim, seconded by Director Junge, moved to approve the CCHHS Compliance Program Operations Plan, as amended. THE MOTION CARRIED UNANIMOUSLY.

B. CountyCare Compliance Plan (Attachment #6)

> Director Junge, seconded by Director Gugenheim, moved to approve the CountyCare Compliance Plan. THE MOTION CARRIED UNANIMOUSLY.

C. Designation of Cathy Bodnar as Chief Compliance Officer (as the CountyCare Compliance Officer) (Attachment #7)

> Director Gugenheim, seconded by Director Junge, moved to approve the designation of Cathy Bodnar as Chief Compliance Officer. THE MOTION CARRIED UNANIMOUSLY.

For information:

D. CountyCare Oversight Meetings (Attachment #8)

IV. Corporate Compliance and Privacy Officer – Information and Action Items (continued)

To receive and file:

E. CountyCare Compliance Steering Committee Charter (Attachment #9)

F. CountyCare Grievances and Appeals Introduction (Attachment #10)

G. FY2014 Compliance Program Activity (Attachment #11)

During the discussion of the information, a question arose regarding staffing levels in Corporate Compliance. Ms. Bodnar stated that at the next Committee Meeting, she will be submitting her 2014 annual report; she will include information on staffing in that report.

> Director Gugenheim, seconded by Director Junge, moved to receive and file the items under Sections IV(E), (F) and (G). THE MOTION CARRIED UNANIMOUSLY.

V. Action Items

A. Minutes of the Audit and Compliance Committee Meeting, June 23, 2014

Director Gugenheim, seconded by Director Junge, moved to accept the minutes of the Audit and Compliance Committee Meeting of June 23, 2014. THE MOTION CARRIED UNANIMOUSLY.

B. Any items listed under Sections III, IV, V and VI

VI. Closed Meeting Items

A. Report from Director of Internal Audit
B. Report from Corporate Compliance and Privacy Officer
C. Discussion of Personnel Matters

Chairman Velasquez, seconded by Director Gugenheim, moved to recess the open meeting and convene into a closed meeting, pursuant to the following exceptions to the Illinois Open Meetings Act: 5 ILCS 120/2(c)(**1**), regarding "the appointment, employment, compensation, discipline, performance, or dismissal of specific employees of the public body or legal counsel for the public body, including hearing testimony on a complaint lodged against an employee of the public body or against legal counsel for the public body to determine its validity," and 5 ILCS 120/2(c)(**29**), regarding "meetings between internal or external auditors and governmental audit committees, finance committees, and their equivalents, when the discussion involves internal control weaknesses, identification of potential fraud risk areas, known or suspected frauds, and fraud interviews conducted in accordance with generally accepted auditing standards of the United States of America." THE MOTION CARRIED UNANIMOUSLY.

Chairman Velasquez declared that the closed meeting was adjourned. The Committee reconvened into the open meeting.

VII. Adjourn

Director Junge, seconded by Director Gugenheim, moved to adjourn. THE MOTION CARRIED UNANIMOUSLY and the meeting adjourned.

Respectfully submitted,
Audit and Compliance Committee of the Board of Directors of the Cook County Health and Hospitals System

XXXXXXXXXXXXXXXXXXXXXX
Carmen Velasquez, Chairman

Attest:

XXXXXXXXXXXXXXXXXXXXXX
Deborah Santana, Secretary

ATTACHMENT #1

CCHHS Audit and Compliance Committee

Internal Audit Report

February 19, 2015

COOK COUNTY HEALTH & HOSPITALS SYSTEM
CCHHS

Meeting Objectives

- **Review Information on the CCHHS Internal Audit function:**
  - **Board Rules – Audit and Compliance Committee**
  - **Charters:**
    - **Audit and Compliance Committee**
    - **Internal Audit**
  - **International Professional Practice Framework**
  - **Internal Audit Strategic Plan**
  - **Internal Audit Organizational Chart**

- **Approve**
  - **Audit and Compliance Committee Charter**
  - **Internal Audit Charter**

- **Closed Session**

Board Rules

- **Rule 4. Organization**
  - **(c) Committees and Subcommittees**
    - **(A) Audit and Compliance**

Charter – Audit and Compliance Committee

- Defines the Committee's role and purpose
- Provides oversight to the CCHHS internal audit and corporate compliance programs
- Monitors systems to ensure the quality of information used by the Board of CCHHS or by external agencies to evaluate CCHHS fiscal affairs and regulatory compliance
- Provides oversight to ensure the Board of Directors and management of CCHHS establish a culture based on honesty and integrity
- Charter originally approved April 2010

Charter – Internal Audit

1. Mission
2. Role
3. Professional Standards
4. Authority
5. Independence
6. Accountability
7. Audit Scope
8. Responsibility

International Professional Practice Framework (IPPF)

1. **The Institute of Internal Auditors (IIA)**
   - ❑ **Global organization of the IA profession**
     - **Professional Standards**
     - **Certifications**
     - **Education and resources**

2. **IPPF**
   - ❑ **Definition of Internal Auditing**
   - ❑ **Code of Ethics**
   - ❑ **International Standards for the Professional Practice of Internal Auditing (the "Standards")**

Internal Audit Strategic Plan

Mission

Internal Audit serves as a trusted advisor to the Board of Directors, its Audit and Compliance Committee, and to the Senior Leadership team and operating management of CCHHS

Vision

Internal Audit provides independent, objective assurance and consulting services to its stakeholders in matters of risk management, controls, and governance. Internal Audit; aligns its activities with CCHHS's mission/strategy, provides customer driven service, provides education, collaborates with stakeholders and customers, promotes the value of good controls and ethical behavior, and provides value-added services to its stakeholders.

Goals	Initiatives
I. Trusted Advisor	• Develop standards to ensure internal auditors are objective • Develop standards to ensure internal auditors are independent • Develop standards to ensure internal audit-derived information is shared only on a "need to know" basis
II. Promote risk management, controls, governance	• Develop Audit and Compliance Committee and Internal Audit Charters • Establish Internal Audit resource plan capable of supporting its Charter • Participate in professional associations • Develop robust risk assessments and internal audit project plans
III. Collaborate with stakeholders	• Periodically reassess stakeholder expectations • Develop communication pieces for Senior Leadership and operating management • Ensure Internal Audit methodology incorporates stakeholder and customer communications in feedback loops
IV. Provide education to stakeholders and customers	• Provide Audit and Compliance Committee information on best practices relating to their roles and responsibilities • Provide Internal Audit strategic plan to Board, Audit and Compliance Committee, Senior Leadership, and operating management • Provide education to stakeholders and customers on internal audit methodologies, risk/control models, and current leading practices

Internal Audit Strategic Plan, continued

Mission

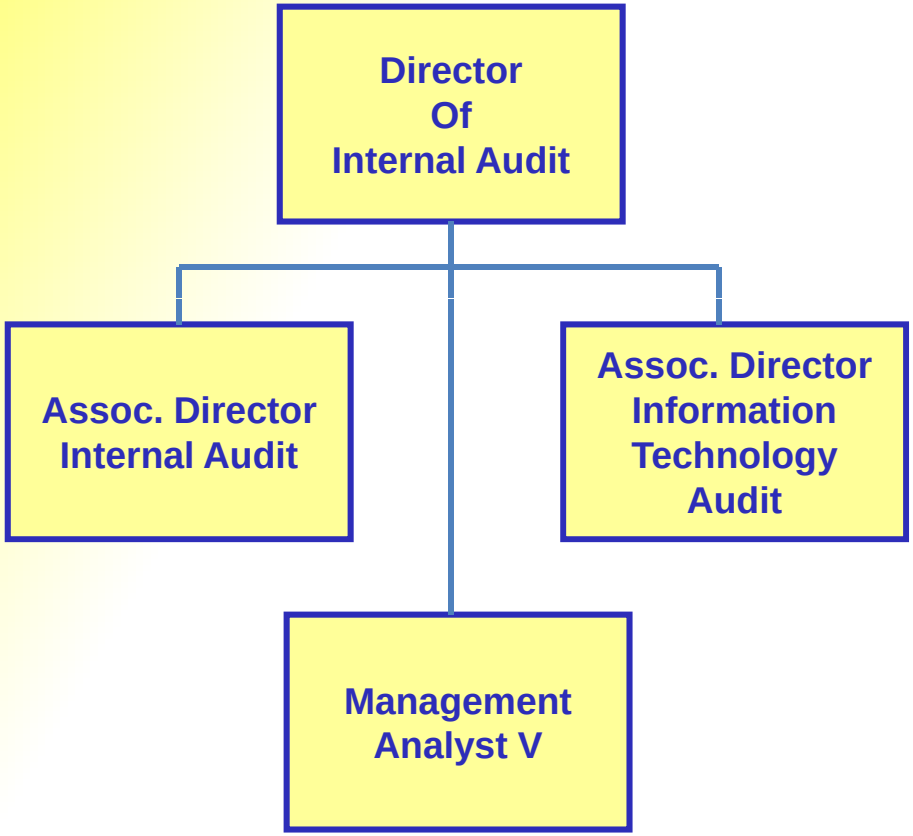
Internal Audit serves as a trusted advisor to the Board of Directors, its Audit and Compliance Committee, and to the Senior Leadership team and operating management of CCHHS

Vision

Internal Audit provides independent, objective assurance and consulting services to its stakeholders in matters of risk management, controls, and governance. Internal Audit; aligns its activities with CCHHS's mission/strategy, provides customer driven service, provides education, collaborates with stakeholders and customers, promotes the value of good controls and ethical behavior, and provides value-added services to its stakeholders.

Goals	Initiatives
V. Provide stakeholders with value added services	• Develop Internal Audit staff and market their capabilities in analytical assessments, projects, and investigations • Ensure Internal Audit recommendations include creative solutions to issues identified by Internal Audit • Ensure Internal Audit follows up on Management's resolution of issues identified by Internal Audit
VI. Provide exceptional customer service	• Develop an Internal Audit quality assurance program which fosters continuous improvement in Internal Audit operations • Develop Internal Audit metrics and scorecards as a basis to measure Internal Audit success

Internal Audit Organization



ATTACHMENT #2

Cook County Health and Hospitals System (CCHHS)
Internal Audit Charter

January 22, 2015

Mission

Internal Audit is an independent, objective assurance and consulting activity designed to add value and improve an organization's operations. It helps an organization accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.

Internal Audit will align its activities with the mission and strategy of CCHHS. Internal Audit will promote good controls and serve as an educational resource to its stakeholders with respect to risk management, control and governance processes. Internal Audit will maintain a collaborative approach to its work practices and will ensure its work product provides value added outputs for its stakeholders.

Role

- Internal Audit's role is determined by the CCHHS Board of Directors through its Audit and Compliance Committee.
- Responsibilities are defined by the CCHHS Board of Directors through its Audit and Compliance Committee.

Professional Standards

- Internal Audit will govern themselves by adherence to the Institute of Internal Audit's "Code of Ethics". http://www.theiia.org/guidance/standards-and-guidance/ippf/code-of-ethics/english/
- The Institute's "International Professional Practice Framework" shall constitute the operating procedures for the department. These documents are considered an addendum to this Charter. http://www.theiia.org/guidance/standards-and-guidance/ippf/standards/
- Internal Audit will adhere to all CCHHS policies and procedures and all Internal Audit procedure manuals.

Authority

Internal Audit is authorized to:

- Have unrestricted access to all functions, records, property and personnel.
- Have free, open, and timely access to the Chief Executive Officer and the CCHHS Board of Directors through its Audit and Compliance Committee.
- Allocate department resources, set frequencies, select subjects, determine scope of work and apply the techniques required to achieve audit objectives.
- Obtain the necessary assistance of personnel in the organization when performing audits, as well as other specialized services from within or outside the organization.

Independence

- All audit activities shall remain free of influence by any element in the organization, including matters of audit scope, procedures, frequency, timing, or report content, required to permit the independence required to render objective reports.
- Internal auditors shall have no operational responsibility or authority over any activities they review.
- Internal auditors shall not develop or install systems or procedures, prepare records or engage in any other activity that they would normally audit.

- Internal Audit reports functionally to the CCHHS Board of Directors through its Audit and Compliance Committee and administratively to the Chief Executive Officer.
- Internal Audit periodically reports to the CCHHS Board of Directors through its Audit and Compliance Committee and to CCHHS Senior Leadership as outlined in the section on Accountability.

Accountability

Internal Audit is accountable to the CCHHS Board of Directors through its Audit and Compliance Committee and to CCHHS Senior Leadership to:

- Report significant issues related to the process for controlling the activities of the organization, including potential improvements to those processes, and provide information concerning such issues through resolution.
- Provide information periodically on the status and results of the annual audit plan and the sufficiency of internal audit resources.
- Coordinate with and provide oversight of other control and monitoring functions.

Audit Scope

The scope of the work of Internal Audit is to determine whether the network of risk management, control and governance processes, as designed and represented by management, is adequate and functioning in a manner to ensure:

- Risks are identified and managed.
- Interaction with various governance groups occurs as needed.
- Significant financial, managerial and operating information is accurate, reliable and timely.
- Employee's actions are in compliance with policies, standards, procedures and applicable laws and regulations.
- Resources are acquired economically, used efficiently, and adequately protected.
- Programs, plans and objectives are achieved.
- Quality and continuous improvement are fostered in control processes.
- Significant legislative or regulatory issues impacting the organization are recognized and addressed properly.

Responsibility

- Develop an annual audit plan using risk-based methodology, including any risk or control concerns expressed by management, and submit the plan to the CCHHS Board of Directors through its Audit and Compliance Committee and to CCHHS Senior Leadership for approval.
- Implement the audit plan and any special requests by the CCHHS Board of Directors, its Audit and Compliance Committee, and CCHHS Senior Leadership and management.
- Maintain a professional audit staff capable of meeting the requirements of this Charter.
- Establish a quality assurance program whereby the director of internal audit assures the operations of internal audit.
- Perform consulting services in addition to assurance services. Consulting services are defined as "advisory and related client services activities, the nature and scope of which are agreed with the client and which are intended to add value and improve the organization's governance, risk management and control processes without the internal auditor assuming management responsibility." Examples include counsel, advice, facilitation, and training.
- Evaluate and assess significant merging/consolidating functions and new or changing services, processes, operations and control processes, coincident with their development, implementation and/or expansion.

- Issue periodic reports to the CCHHS Board of Directors through its Audit and Compliance Committee and to CCHHS Senior Leadership summarizing results of internal audit activities.
- Inform the CCHHS Board of Directors through its Audit and Compliance Committee, and CCHHS Senior Leadership of emerging trends and successful practices in internal auditing.
- Provide the CCHHS Board of Directors through its Audit and Compliance Committee, and CCHHS Senior Leadership a list of internal audit measurement goals and results.
- Assist in the investigation of significant suspected fraudulent activities.
- Consider the scope of work of the external auditors and regulators for the purpose of providing optimal audit coverage at a reasonable cost.

_____
Carmen Velasquez
Audit and Compliance Committee Chair

_____
Dr. Jay Shannon
Chief Executive Officer

_____
Tom Schroeder
Director of Internal Audit

ATTACHMENT #3

Charter for the Audit & Compliance Committee

The Charter,

- Defines the Committee's role and purpose.
- Provides oversight to the CCHHS internal audit and corporate compliance programs.
- Monitors that systems are in place to ensure the quality of information used by the Board of CCHHS or by external agencies to evaluate the fiscal affairs and regulatory compliance.
- Provides oversight to ensure the Board of Directors and management of CCHHS establishes a culture based on honesty and integrity.
- Originally approved in April 2010.

- Action: Review and Approve.

COOK COUNTY HEALTH & HOSPITALS SYSTEM CCHHS	Category: CHARTER POLICY	
Subject: CHARTERS FOR THE BOARD OF DIRECTORS	Page: 1 of 4	
Title: AUDIT & COMPLIANCE COMMITTEE OF THE BOARD OF DIRECTORS CHARTER	Revision of: 01/22/2010	Approval Date: 04/16/2010

This document sets forth the duties, responsibilities, and governs the operations of the Audit & Compliance Committee of the Board of Directors of Cook County Health & Hospitals System (CCHHS), a comprehensive, integrated system of healthcare throughout Chicago and suburban Cook County through its hospitals, ambulatory and community health network clinics, public health department, and correctional healthcare facility. ~~, and outpatient infectious disease center.~~

PURPOSE

The CCHHS Board of Directors ("Board") and the Chief Executive Officer ("CEO") are committed to the proper oversight of our Audit and Compliance programs. In furtherance of this objective, the Board initiated an Audit and Compliance Committee[1] composed of independent directors.

The purpose of the Committee is to provide oversight to the CCHHS internal audit and corporate compliance programs and monitor that systems are in place to ensure the quality of information used by the Board of CCHHS or by external agencies to evaluate the fiscal affairs and regulatory compliance. Additionally, the Audit and Compliance Committee will provide oversight to ensure the Board of Directors and management of CCHHS establishes a culture based on honesty and integrity.

The Committee shall advise the Board in matters relating to
(1) the integrity of CCHHS financial reporting,
(2) the effectiveness of CCHHS internal control over financial reporting,
(3) the performance and effectiveness of CCHHS internal audit and corporate compliance programs and the independent public accountants,
(4) the implementation of standards and processes to ensure professional responsibility and honest behavior,
(5) the compliance with regulatory requirements, as they relate to and impact the operational areas above, and
(6) risk management, as it relates to internal audit and corporate compliance.

POLICY

1. The Board has established a Committee charged with the responsibility of providing oversight to the internal audit and corporate compliance programs of the organization and ensuring the organization has adopted and implemented policies and procedures that will ensure compliance with all applicable laws, regulations, and policies.
2. The primary goals of the Committee are to
   (a) assist the Board in fulfilling its fiduciary responsibilities relating to the regulatory and financial compliance with applicable laws, regulatory requirements, industry guidelines, and policies;

[1] Since the 1940s, this has been preferred method to provide financial oversight within their companies. For the last decade, the Office of Inspector General (OIG) in their compliance guidance has also promoted the same approach in ensuring compliance with all applicable laws and regulations. The OIG believes that creation of Board leadership "as a first step, a good faith and meaningful commitment on the part of the … administration, especially the governing body and the CEO, will substantially contribute to a program's successful implementation." They also see that effective Board oversight of compliance as one of their critical fiduciary responsibilities.

(b) ensure the organization has adopted and implemented policies and procedures which will require CCHHS to act in compliance with applicable laws, regulations, and policies. This includes but is not limited to the quality and integrity of accounting, auditing, and compliance reporting methodologies and financial reporting that reflects the condition of the organization in all material respects;
(c) review and approve annual internal audit and corporate compliance program plans and monitor the ongoing progress of said plans;
(d) address and review matters concerning or related to the internal audit and corporate compliance programs; and
(e) provide a vehicle for communication between the Board, CCHHS management, and the independent auditors concerning the internal audit and corporate compliance programs.

DEFINITIONS

"Counsel" refers to CCHHS Office of General Counsel or outside counsel as designated.

"Chief Compliance Officer" means the System Chief Compliance and Privacy Officer or his/her staff as designated by the Chief Compliance Officer.

"Director of Internal Audit" means the System Director of Internal Audit or his/her staff as designated by the Director of Internal Audit.

PROCEDURES

The Committee shall:

1. Be comprised of three to five Board members with working knowledge of a health system, none of whom is an officer or employee of the organization, its subsidiaries or affiliates with one of which shall be deemed a financial expert.
2. Be independent of management and free of any relationship that, in the opinion of the Board, would interfere with the exercise of independent judgment as a committee member.
3. Have the authority to hire, terminate, and determine the compensation for the Chief Compliance Officer and the Director of Internal Audit.
4. Have the authority to engage independent counsel and other advisors, as it determines necessary to carry out its duties.
5. Provide independent oversight of CCHHS internal audit and corporate compliance programs, financial reporting processes, internal controls and independent auditors.
6. Meet in advance of meetings of the Board, at least four times annually and more frequently, as necessary and shall make recommendations to the Board annually, after consultation with the Chief Executive Officer, on those findings and matters within the scope of their responsibility.
7. Maintain minutes of all its meetings to document its activities and recommendations.
8. Meet periodically with the Chief Compliance Officer, Director of Internal Audit, and the independent auditors to be kept informed on their independent evaluation of compliance with legal, regulatory, financial, accounting and auditing practices.

9. Committee has the right to hold executive closed sessions pursuant to Illinois Open Meetings Act: 5 ILCS 120/2(c)(11) as needed to review and discuss matters as they relate to the Committee.
10. Review policies and procedures relating to the integrity of financial information of the organization and those other related entities for the purpose of assuring adequacy of the internal controls and financial operations.
11. Review and approve annual internal audit and corporate compliance program plans and monitor the ongoing progress of said plans and ensure any related work is coordinated with the independent auditors.
12. Meet with the independent auditors and financial management to review the scope of the proposed audit for the current year and the audit procedures to be utilized and at the conclusion thereof review such audit, including any comments or recommendations of the independent auditors.
13. Review changes in the accounting standards and applicable policies and procedures with the independent auditors. Make appropriate recommendations to management and the Board on the findings included in the independent auditors' management letter.
14. Review the financial statements contained in the annual report with management to ensure that they are timely and free from material errors and that all appropriate disclosures are made. Determine that the independent auditors are satisfied with the disclosure and content of the financial statements.
15. Provide oversight to the implementation of the corporate compliance program, and ensure adherence to the Standards of Conduct and Governmental Rules and Regulations and recommend any revisions thereto, as appropriate.
16. Provide oversight to the corporate compliance program relating to the conduct of business that will ensure that high ethical and conduct standards are met. Ensure the mission, values, and Standards of Conduct are properly communicated to all employees on an annual basis.
17. Review matters relating to education, training and communication in connection with the Standards of Conduct to ensure that the policies and procedures on compliance are properly disseminated, understood and followed.
18. Present to the Board, as appropriate, such measures and recommend such actions as may be necessary or desirable to assist CCHHS in conducting its activities in compliance with applicable regulations, policies, and the Standards of Conduct. This includes the results of individual audits, related findings and management’s response to said findings.

ORIGINAL APPROVAL

At the Audit & Compliance Committee of the Board of Directors of the Cook County Health and Hospitals System on Friday, April 16, 2010 at John H. Stroger, Jr. Hospital of Cook County, 1901 W. Harrison Street, in the fifth floor conference room, Chicago, Illinois.

SUBSEQUENT APPROVAL

At the Audit & Compliance Committee of the Board of Directors of the Cook County Health and Hospitals System on <<insert day and date>> at 1900 West Polk, 2nd Floor Conference Room, Chicago, Illinois.

REVIEW HISTORY:

Written: January 22, 2010
Updated: April 16, 2010
Updated:

ATTACHMENT #4

Corporate Compliance Report

Cathy Bodnar, MS, RN, CHC

Chief Compliance & Privacy Officer

February 19, 2015

Meeting Objectives

To Review and Approve the:

- CCHHS Compliance Program Operation Plan
- CountyCare Compliance Plan
- Designation of the Chief Compliance and Privacy Officer *(to formally integrate CountyCare)*

For Information Only:

- CountyCare Oversight Meetings Summary

To Receive and File:

- CountyCare Compliance Steering Committee Charter
  - CountyCare Fraud, Waste and Abuse Program
- County Care Grievances and Appeals Introduction
- FY 2014 Corporate Compliance Program Annual Statistics

COOK COUNTY HEALTH & HOSPITALS SYSTEM CCHHS

CCHHS Compliance Program Operation Plan

The CCHHS Operation Plan,

- Summarizes the essence of the CCHHS Compliance Program
- Demonstrates the organization's commitment to promoting ethical and lawful conduct consistent with all applicable laws, regulations, and contractual requirements, as well as CCHHS policies, procedures, and Code of Ethics/Standards of Conduct.
- Parallels the elements of an effective compliance program as recommended through Federal Sentencing Guidelines and the HHS Office of Inspector General Compliance Program Guidance publications and is required by the CMS Managed Care Program Integrity requirements.
- Originally approved in April 2010.

- Action: Review and Approve

Corporate Compliance Program

Insert Date of Adoption
Cook County Health and Hospital Systems

PROGRAM LEAD:

Cathy Bodnar, MS, RN, CHC
Chief Compliance and Privacy Officer
Cook County Health & Hospitals System

APPROVAL PARTIES:

Audit & Compliance Committee of the Cook County Health & Hospitals System Board of Directors
Originally Approved on July 16, 2010
Reviewed and Approved on <<insert date>>

John Jay Shannon, MD
Chief Executive Officer
Cook County Health & Hospitals System
Electronically Approved on January 30, 2015

CountyCare Compliance Plan

The CountyCare Compliance Plan,

- Summarizes the CountyCare Compliance Plan, as required by the Managed Care Community Network (MCCN) Contract with the Department of Healthcare and Family Services (HFS).
- Parallels the elements of an effective compliance program recommended through Federal Sentencing Guidelines and Compliance Program Guidance and is required by CMS Managed Care Program Integrity requirements. The CountyCare Compliance Plan also contains additional information regarding CountyCare procedures to prevent and detect fraud, waste and abuse and manage grievances and appeals.
- The CountyCare Compliance Plan will be managed and maintained by the CCHHS Office of Corporate Compliance, in collaboration with the Third Party Administrator, IlliniCare.

- Action: Review and Approve

CountyCare Compliance Plan

Insert Date of Adoption

PROGRAM LEAD:

Cathy Bodnar, MS, RN, CHC
Chief Compliance and Privacy Officer
Cook County Health & Hospitals System

APPROVAL PARTIES:

Audit & Compliance Committee of the Cook County Health & Hospitals System Board of Directors
Approved on <<insert date>>

John Jay Shannon, MD
Chief Executive Officer
Cook County Health & Hospitals System
Electronically Approved on January 30, 2015

Expanding the Role of the Chief Compliance Officer

Designation of the Chief Compliance Officer

- Supports contractual obligation to define and delegate compliance responsibilities for the Health Plan.
- Comports with best practice for Board and CEO approval.
- Existing job description of the Chief Compliance and Privacy Officer job allows for incorporation of duties.

- Action: Review and Approve

NON-DIRECT PATIENT CARE JOB DESCRIPTION

TITLE: Chief Compliance Officer
Job Code: Grade: 24
Reports To: CCHHS Board of Directors and the Chief Executive Officer

POSITION SUMMARY

Brief summary of position.

The Chief Compliance Officer is also the Chief Privacy Officer, this position reflects the mission and vision of Cook County Health & Hospitals System (CCHHS) and oversees the CCHHS Corporate Compliance Program[1], functioning as an independent and objective body that reviews and evaluates compliance issues/concerns within the organization. The position ensures the Board of Directors, senior management and workforce are in compliance with the rules and regulations of regulatory agencies, that company policies and procedures are being followed, and that behavior in the organization meets the CCHHS Standards of Conduct (Code of Ethics).

The Corporate Compliance Office exists (1) as a channel of communication to receive and direct compliance issues to appropriate CCHHS resources for investigation and resolution, and (2) as a final internal resource with which concerned parties may communicate after other formal channels and resources have been exhausted.

REPORTING STRUCTURE

The Chief Compliance Officer reports to the CCHHS Board of Directors through the Audit and Compliance Committee of the Board and the Chief Executive Officer.

RESPONSIBILITIES

Fundamental job duties for which this position is accountable.

- Provides oversight and guidance for the Board of Directors, Chief Executive Officer, and senior management on matters relating to compliance.
- Monitors and reports results of organizational compliance/ethics efforts. The Chief Compliance Officer is authorized to implement all necessary actions to ensure achievement of the objectives of an effective compliance program.
- Develops, initiates, maintains, and revises policies, procedures and practices for the general operation of CCHHS and its related activities to prevent illegal, unethical, or improper conduct.
- Guides and partners with operational leadership to facilitate operational ownership of compliance.
- Monitors organizational compliance activities of CCHHS.
- Develops and periodically reviews and updates Standards of Conduct to ensure continuing relevance in providing guidance to management and employees.
- Collaborates with operational areas throughout the organization to direct compliance issues to appropriate channels for investigation and resolution. Consults with the legal counsel as needed to resolve difficult legal compliance issues.
- Responds to alleged violations of rules, regulations, policies, procedures, and the CCHHS Standards of Conduct by evaluating or recommending the initiation of investigative procedures. Develops and oversees a system for uniform handling of such violations.
- Acts as an independent review and evaluation body to ensure that compliance issues/concerns are being appropriately evaluated, investigated and resolved.
- Identifies potential areas of compliance vulnerability and risk; develops/implements corrective action plans for resolution of problematic issues, and provides general guidance on how to avoid or deal with similar situations in the future.
- Ensures proper hospital reporting of violations or potential violations to duly authorized enforcement agencies as appropriate and/or required.
- Establishes and provides direction and management of a system compliance hot line.
- Establishes and monitors a system to log and track all concerns/issues raised to Corporate Compliance.
- Institutes and maintains an effective compliance communication program for the organization, including promoting (a) use of the compliance hotline, (b) heightened awareness of ABC Hospital codes of conduct, and (c) understanding of new and existing compliance issues and related policies and procedures.
- Works with CCHHS Human Resources Department and others as appropriate to develop an effective compliance training program, including appropriate introductory training for new employees as well as ongoing training for all employees and managers.
- Monitors the performance of the Compliance Program and related activities on a continuing basis, taking appropriate steps to improve it effectiveness.
- Supervises the Corporate Compliance Department to insure department goals are met.
- Provides reports on a regular basis, and as directed or requested, to keep the Board of Directors and senior management informed of the operation and progress of compliance efforts.

EDUCATION/EXPERIENCE QUALIFICATIONS

Level of education and experience that is required for the position.

Required

- Masters Degree in Healthcare, Business, Education, or related field.
- Professional Certification: Certified in Heathcare Compliance (CHC)
- Ten (10) years experience in a healthcare organization, to include demonstrated leadership. Familiarity with operational, financial, quality assurance, and human resource procedures and regulations is necessary.
- Five+ (5+) years recent leadership experience in healthcare compliance
- Seven+ (7+) years of conducting complex healthcare compliance investigations
- Maintains a high degree of credibility, independence, integrity, confidentiality and trust. Strong communication and leadership skills are essential.
- Demonstrates sound business judgment and is supportive of the system mission and objectives. Commands respect of the senior management team, board level committees and other members of the compliance team.
- Strives to develop partnerships, teamwork and good working relationships. Maintains an open management style.
- Understands the complexities of a large, diverse, public, safety-net organization. Involves others appropriately in consultations and decisions.
- Understands the legal regulatory framework of the entity.
- Exhibits analytical skills and an understanding of operational processes and technology concepts.
- Maintains strong writing skills required to write and edit policies and procedures, issue memorandums and compile program reports.
- Exhibits exceptional presentation skills with large and small audiences.
- Able to operate successfully in a constantly changing, fast-paced environment. Demonstrates initiative, self-motivation, practical learning skills, enthusiasm, and an ability to complete multiple tasks in a timely and accurate manner.
- Software application skills – MS Office Access, Excel, PowerPoint, and Word.

Desired

- Juris Doctor (J.D.)
- Professional Certification: RHIA, RN, CPA, or CFE, Current & Active

Note:
This job description was developed through the review of multiple position descriptions published through the Heath Care Compliance Association (HCCA), a nationally recognized professional organization of healthcare compliance professionals.

[1] Section 6401 of the Affordable Care Act requires healthcare providers participating in federal healthcare programs to establish compliance and ethics programs that contain certain "core elements" as a condition of participation. The core elements can be found within the Department of Health and Human Services (HHS), Office of Inspector General published Compliance Program Guidance in 1998 and Supplemental Guidance in 2005, these documents, along with the Federal Sentencing Guidelines provide the foundation for Compliance Programs.

CountyCare Health Plan Oversight Meetings

Oversight meetings

- Fulfills our contractual requirement to manage and provide oversight for health plan operations.

- Action: None. Awareness only.

CountyCare Health Plan Oversight Committee Meetings

HEALTH PLAN OVERSIGHT COMMITTEE MEETING DESCRIPTION

Note: These oversight meetings fulfill MCCN requirements to have internal operational committees to manage and provide oversight for health plan operations. This document summarizes the various oversight committees.

Executive Committee

The CountyCare Executive Committee meets monthly and is comprised of CCHHS senior delegates and CountyCare leadership. The Executive Committee is responsible for providing the oversight, guidance and support to CountyCare leadership to support the achievement of agreed upon goals in a manner consistent with a provider sponsored organization and focused on improving the health status of underserved/at–risk populations in a fiscally appropriate manner. The Executive Committee will provide useful feedback to Plan leadership regarding Plan performance and promote alignment between CCHHS objectives and Plan programs.

Frequency: Monthly

CountyCare Finance Committee

The committee meets monthly and is responsible for recommending financial policies, goals, and budgets that support the mission, values, and strategic goals of CountyCare. The committee also reviews the organization's financial performance against its goals and proposes major transactions and programs to the board.

Frequency: Monthly

CountyCare Compliance Committee

This committee provides oversight of and guidance to CountyCare operations to fulfill Compliance Program requirements, which include the implementation and operation of the Compliance Program. The Compliance Committee will review CountyCare activity pursuant to Compliance Program requirements and contractual requirements. This would include reviews of, but not limited to, audits, monitoring activity, and corrective action plans. Based on these reports, the Compliance Committee will make recommendations to operations as necessary.

Frequency: Monthly

Quality Improvement Committee (QIC)

The QIC meets quarterly and promotes a system-wide approach to QI, provides oversight and direction in assessing the availability, access and appropriateness of care and services delivered and continuously enhances and improves the quality of care and services provided to members. This is accomplished through a comprehensive system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems; the identification of opportunities to improve member outcomes; and the education of members, providers and staff regarding the Quality Assessment and Performance Improvement (QAPI) Program.

Frequency: Quarterly

Committee Reporting to the QIC

Utilization Management (UM) Committee

The UMC's primary purpose is to provide oversight of the utilization management program, care coordination/case management program and associated activities to ensure that UM activities are integrated into all functional areas and departments. The UMC meets at least quarterly and is responsible for the analysis of UM data (such as hospital admission, ambulatory encounters, and the level of care utilized), care coordination/case management data (such as completion rates of HRS/HRA, number of enrollees in care coordination by risk level and by disease process), the identification of trends, and the addressing of identified issues. Additional responsibilities include the monitoring of the appropriateness of care, over- and under-utilization of services, review and approval of medical necessity criteria.

Frequency: Quarterly

C (continued)

ittee

rly and will have oversight of and operating authority over the health plan's Pharmacy Program. The the development and annual review of the Pharmacy Program Description and associated policies, ving pharmacy utilization; specific Drug Utilization Review studies, particularly on the poly-pharmacy eraction reports.

C) is an ad hoc committee of the QIC and is responsible for reviewing inappropriate or aberrant ged quality of care concerns, adverse events, and sentinel events where initial investigation significant, severe adverse outcome has occurred or other cases as deemed appropriate. The PRC gment in assessing the appropriateness of clinical care and recommending a corrective action plan vider's situation.
asis

municate CountyCare's programs and processes to its provider network. The Committee provides profile and incentive programs, and other administrative practices, and supports development of the seful analyses of the data, and effective means of helping Providers improve their performance.
asis

l ensure network providers, facilities and practitioners are qualified, properly credentialed and ers. The CC has the responsibility for credentialing and re-credentialing physicians, non-physician are providers, and other practitioners in the plan network and to oversee the credentialing process to ory and accreditation requirements.

n
(PIT) is an internal, cross-functional quality improvement team that facilitates the integration of a ughout the organization. The PIT is responsible for gathering and analyzing performance measures, analysis for indicators falling below desired performance and making recommendations regarding r improvement. The PIT is also responsible for overseeing the implementation of recommended m the QIC and/or its supporting subcommittees, monitoring the outcomes of those improvement esignated committee. Multiple PITs may exist.
schedule will be developed

ity Stakeholder Committee

unity Stakeholder Committee meets on a quarterly basis to provide feedback to the QIC on health and community perspectives; recommends program enhancements based on Enrollee and rogram issues, such as disparities, that may impact community groups; provides input on service e on effective approaches for reaching Enrollees or other Enrollee-related issues. These committees faction survey results; evaluates performance levels and telephone response times; reviews Enrollee e, understanding and ease of use; evaluates network access issues; and provides feedback as

Frequency: Quarterly

d the QIC

s affecting the scope of functions of delegated vendors and requirements, including Key Performance Indicators. The audits, monthly joint operations meetings and regular monitoring of

pring Member grievances and appeals including those arising from evances and appeals to assess the trends and patterns in addition to and making recommendations regarding corrective actions, as

ent Integrity (PI) and Special Investigations Unit (SIU) activities, ring relevant information.

on an annual basis.

CountyCare Compliance Steering Committee Charter

The Charter

- Fulfills contractual requirements that compels the development of a Compliance Committee to oversee the health plan's Fraud Waste and Abuse Plan and operations.
- This document outlines the charter statement for the committee, the various inputs that will be considered by the committee, the communications and reports generated by the committee, as well as the voting rights for committee members.
- The CountyCare Corporate Compliance Committee is chaired by the CCHHS Compliance and Privacy Officer and meets on a monthly basis and contains membership from both CCHHS leadership, CountyCare leadership, IlliniCare (TPA) compliance and operations.

- Action: Receive and File

CountyCare Compliance Steering Committee Charter

Chair: CCHHS Chief Compliance Officer
Reports to: CCHHS Board of Directors through the Audit and Compliance Committee
Frequency: Monthly
Implemented: 08/21/2014
Last reviewed/ revised: as above

Charter Statement: To provide oversight and guidance of CountyCare operations to fulfill Compliance program requirements and monitor corrective action plans as necessary.

Inputs to the Compliance Committee:

- Compliance Plan 2014
- Fraud, Waste and Abuse (FWA) Reports
  - Hotline Reports
  - Investigations
    - SIU Report
- Reports/Audits
  - Grievances and Appeals Reports
  - Sanction Screening Reports
  - Conflict of Interest Reports
  - Delegated Vendor Oversight & Audits
  - Upcoming Audits
- Training Reports
  - FWA
  - HIPAA
  - Cultural Competency
  - Health, Safety and Welfare
  - Provider Education
- Policy and Procedures
  - Development/Review
  - Audits
- HIPAA Updates
- Quality Improvement Plans – Current/Status
- Corrective Action Plans – Current/Status
- Identification of New Organizational Risks

Communications

- Recommendations/Corrective Actions

Key audiences:

- Executive Oversight Committee
- CCHHS Board of Directors through the Audit and Compliance Committee
- Plan Administration

Voting:
All members, including the chair, have one vote. In the event a member is not present, they can send an alternate on their behalf. The alternate can cast the vote for the member. At least 50% of the voting members, or their delegates, must be present for quorum. Any vote must be approved by at least 2/3.

Reporting:
The main reporting tool from the Compliance Committee is the Meeting Minutes. A summary of the meeting will be provided to the CCHHS Board of Directors through the Audit and Compliance Committee.

CountyCare Fraud, Waste and Abuse Program

The Program

- Monitors the Health Plan's Fraud, Waste and Abuse (FWA) Program with goal of protecting consumers in the delivery of healthcare services through timely detection, investigation and prosecution of FWA.
- Achieves goal by establishing:
  - Training programs for CountyCare employees, vendors, subcontractors, about their role in the FWA process.
  - Defining methods to identify, prevent, review and initiate corrective actions against any provider or member who is suspected of participating in FWA activities.
  - Developing policies and procedures.
  - Outlining the workflow to be followed in the event that a potential FWA issue or overpayment is identified.
  - Reporting identified FWA issues, including referral to state and local authorities.
- Oversees all FWA activities performed by Health Plan's delegated vendors.

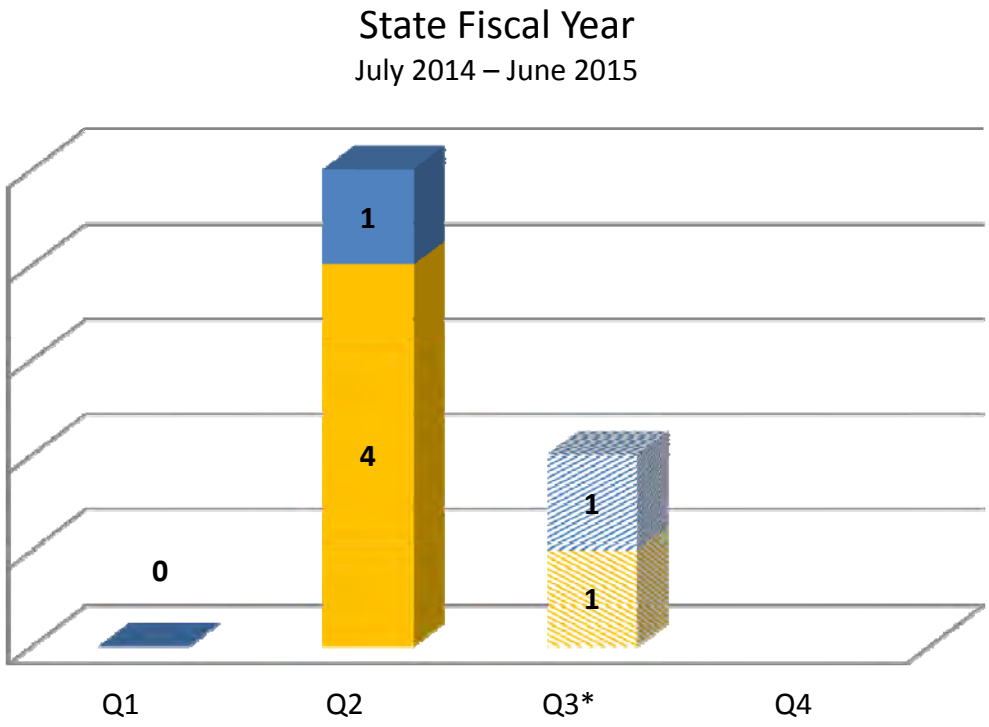
- Action: Receive and File

countycare	**CountyCare Fraud, Waste and Abuse Workgroup** **Date:** **Time:** **Place:** **Dial in #:** **Leader: Ryan Lipinski, CountyCare Compliance Officer**
Meeting Purpose:	Monthly Workgroup meetings are responsible for reviewing Fraud, Waste and Abuse Programs of delegated vendors. This meeting will include Payment Integrity (PI) and Special Investigations Unit (SIU) activities, taking appropriate action, and assisting the PI/SIU groups in procuring relevant information.
Primary Attendees:	**Members**: CCHHS; CountyCare **Staff**: TPA; Other Delegated Vendors **Other**: CC OIG

Sample Agenda Topics

Review of Delegated Vendors Fraud Waste and Abuse (FWA) Policies and Procedure
Dashboard Statistics Development
2015 FWA Work Plan
Report Review • PI/SIU Report Review
Status of Open Investigations • Investigation Name • Referral Type • Referral Source • Investigation Phase/Status • Preliminary Review Finding and Recommendation • Final Report Generated (Y/N) • Recommended Action Taken
Referrals made to and/or received from HFS OIG
FWA Program Updates • New staffing changes or program oversight responsibilities • New regulations or guidance impacting FWA subject area • Employee training or professional development associated with FWA operations (e.g., conferences, webinars attended)
FWA – Open Items

FWA Activity



Q3* = only 1-month of data (January)
Note: HFS requires quarterly reporting using the State Fiscal Year

Seven (7) cases identified to date:

- Four (4) Providers
  - Potential upcoding on two (2)
  - Potential "boiler plate" coding on one (1)
  - One (1) provider misidentified as CountyCare (case closed)
- Two (2) Ambulance Providers
  - Potential upcoding
- One (1) Member
  - Allegation of ineligibility (transitioned to HFS OIG – closed)

CountyCare Grievances and Appeals Process

The Process

- Provides a mechanism for members to file complaints and a way for members or providers to file appeals when a request for a medical item or service is denied by CountyCare.
- Allows for tracking of grievances and appeals by category, volume and resolution.
- Contributes to identify program improvement opportunities, which may reduce the issues that give rise to grievances and appeals.
- Represents a primary mechanism for CCHHS Corporate Compliance and CountyCare operations to exercise oversight of the TPA and other vendor operations with respect to grievances and appeals.

- Action: Receive and File

GRIEVANCES AND APPEALS DEFINITIONS

Contractor shall submit a summary of the Grievances and Appeals filed by Enrollees, organized by categories of as defined below. The report shall include a summary count of any such Grievances or Appeals received during the reporting period including those that go through fair hearings and external independent reviews. The report shall include Appeals and Grievances outcomes and the levels at which the Grievances or Appeals were resolved and whether the appeals were upheld or overturned. Contractor shall provide this report for each population for which it provides Covered Services. ***Reporting Frequency: Quarterly***

Section	Term	Definition
Types	**Grievance**	The expression of dissatisfaction by a Member including complaints and requests for disenrollment, about any matter other than a matter that is properly the subject of an appeal.
	Appeal	A request for review of a decision made by CountyCare with respect to an action. An action is defined as the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the State; the failure to act within the set timeframes.
	Expedited Appeal	An appeal filed when taking the time for a standard (appeal) resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function.
	External Independent Review	Except for denial or Waiver services, which may not be reviewed by an external independent entity, the Enrollee may request an external independent review, both standard and expedited timeframes, of appeals that are denied by Contractor within thirty (30) calendar days after the date of the Contractor's decision notice [HFS].
	Fair Hearing	The State plan must provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly. Final decisions of Appeals not resolved wholly in favor of the Enrollee may be appealed by the Enrollee to the State under its Fair Hearings system within thirty (30) calendar days after the date of the Contractor's Decision Notice.
Section	**Term**	**Definition**
Categories	**Medical Necessity**	Determinations on decisions that are or which could be considered covered benefits. This includes determinations for covered medical benefits as defined by the organization, including hospitalization and emergency services listed in the Certificate of Coverage or Summary of Benefits and care of service that could be considered either covered or non-covered, depending on the circumstances.
	Access to Care	Areas of concerns such as: cannot find Provider, inconvenient hours, Provider capacity, out of area Providers, refusal to take Medicaid, ADA non-compliance, unable to address language needs, not meeting appointment times requirements.
	Quality of Care	The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.
	Transportation	Any grievance or appeal relating to the transportation benefits.
	Pharmacy	Any grievance or appeal relating to the pharmacy benefits.
	HCBS Waiver Services	*Grievance:* Any expression of dissatisfaction relating to HCBS Waiver Services. *Appeal:* Any appeal related to the reduction, elimination, or timeliness of services or hours through the Community Care Program or the Home Services Program.
	Long Term Care (LTC) Services	*Grievance:* Any expression of dissatisfaction relating to LTC Services. *Appeal:* Any appeal related to the reduction, elimination, or timeliness of services or hours through the Community Care Program or the Home Services Program.
	Other	Any kind of grievance or appeal not covered by the previously mentioned topics.

GRIEVANCE AND APPEALS SUMMARY
July 2014 – September 2014
Q1 , SFY 2015

Grievances and Appeals Received

Category	Medical Necessity	Access to Care	Quality of Care	Transportation	Pharmacy	HCBS Waiver Services	LTC Services	Other	Total
Grievances	-	12	41	1	1	-	-	1	56
Appeals	-	-	-	-	4	-	-	-	4
Expedited Appeals	-	-	-	-	-	-	-	-	-
Total	-	12	41	1	5	-	-	1	60

Grievances and Appeals Resolved

Category	Medical Necessity	Access to Care	Quality of Care	Transportation	Pharmacy	HCBS Waiver Services	LTC Services	Other	Total
Grievances	-	9	39	-	-	-	-	-	48
Appeals	-	-	-	-	2	-	-	-	2
Expedited Appeals	-	-	-	-	16	-	-	-	-
Total	-	-	39	-	18	-	-	-	50

Grievances Outcomes

Category	Total # of Grievances Resolved	# of Grievances Resolved within 90 Days	% of Grievances Resolved within 90 Days
Grievances Resolved	48	48	100%

Appeals Outcomes

Category	Upheld	Overturned	# of Appeals Resolved within 15 Business Days	% of Appeals Resolved within 15 Business Days
Appeals Upheld/Overturned at MCO Level	1	1	2	100%
Total	1	1		

Expedited Appeals Outcomes

Category	Upheld	Overturned	# of Expedited Appeals Resolved within 24 Hours	% of Expedited Appeals Resolved within 24 Hours
Expedited Appeals Upheld/Overturned at MCO Level	-	-	-	N/A
Total	-	-		

GRIEVANCE AND APPEALS SUMMARY
October 2014 - December 2014
Q2 , SFY 2015

Grievances and Appeals Received

Category	Medical Necessity	Access to Care	Quality of Care	Transportation	Pharmacy	HCBS Waiver Services	LTC Services	Other	Total
Grievances	-	4	33	5	-	-	-	13	55
Appeals	15	-	-	-	32	-	-	-	47
Expedited Appeals	-	-	-	-	16	-	-	-	16
Total	15	4	33	5	48	-	-	13	118

Grievances and Appeals Resolved

Category	Medical Necessity	Access to Care	Quality of Care	Transportation	Pharmacy	HCBS Waiver Services	LTC Services	Other	Total
Grievances	-	3	10	-	-	-	-	5	18
Appeals	10	-	-	-	29	-	-	-	39
Expedited Appeals	-	-	-	-	16	-	-	-	16
Total	10	3	10	-	45	-	-	5	73

Grievances Outcomes

Category	Total # of Grievances Resolved	# of Grievances Resolved within 90 Days	% of Grievances Resolved within 90 Days
Grievances Resolved	18	18	100%

Appeals Outcomes

Category	Upheld	Overturned	# of Appeals Resolved within 15 Business Days	% of Appeals Resolved within 15 Business Days
Appeals Upheld/Overturned at MCO Level	-	10	10	100%
Total	-	10		

Expedited Appeals Outcomes

Category	Upheld	Overturned	# of Expedited Appeals Resolved within 24 Hours	% of Expedited Appeals Resolved within 24 Hours
Expedited Appeals Upheld/Overturned at MCO Level	3	13	7	43.75%
Total	3	13		

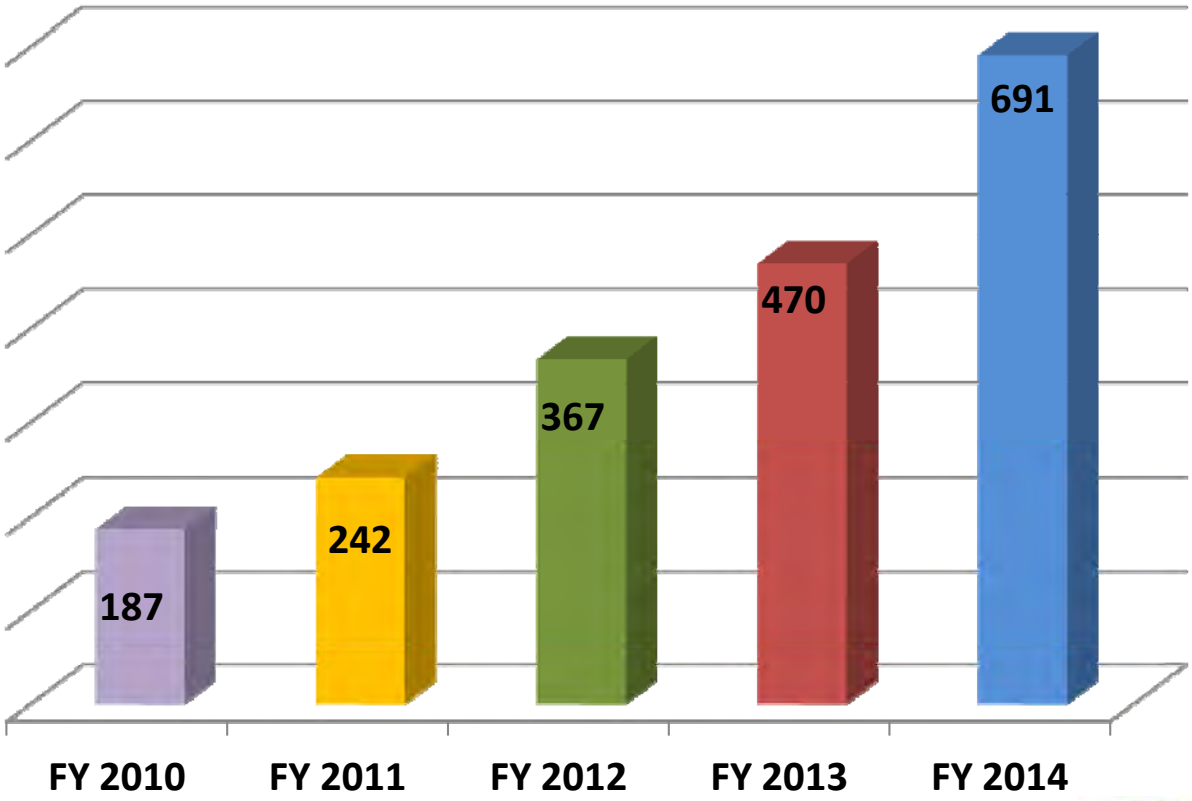
Fiscal Year End Report

This Report

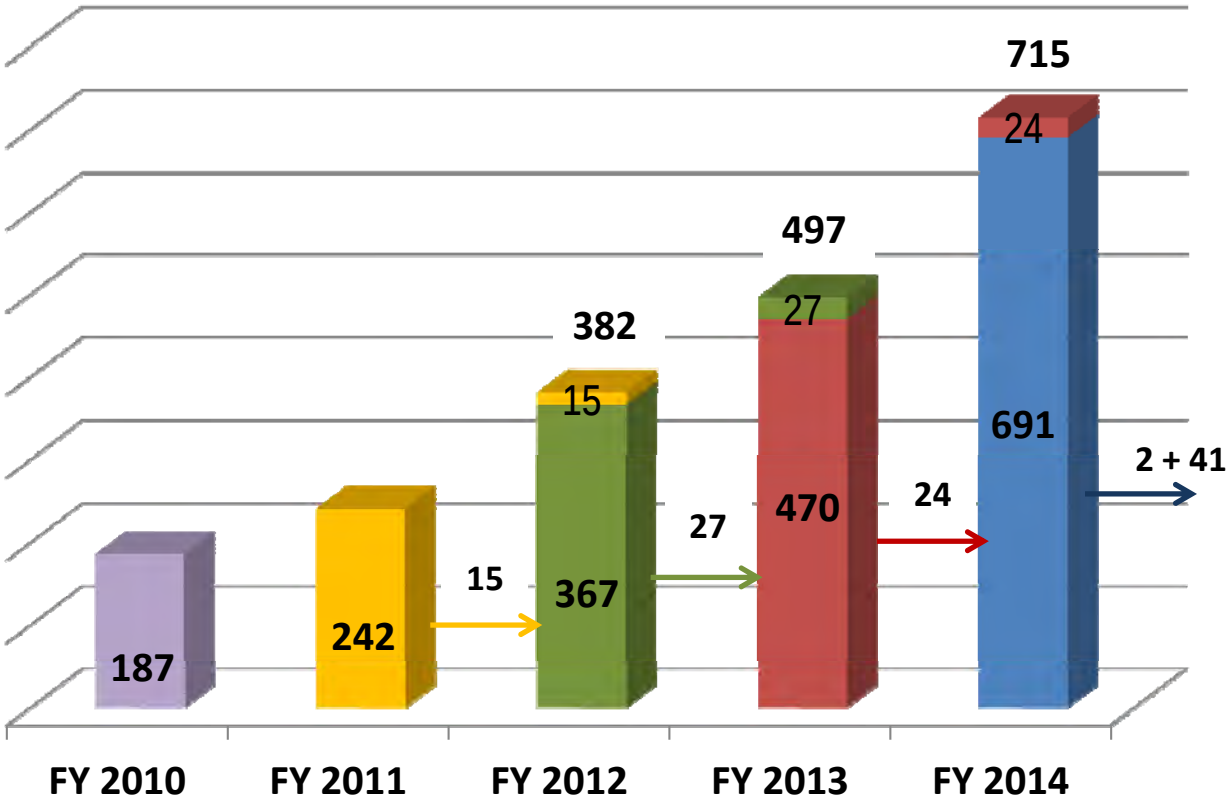
- Summarizes FY 2014 Corporate Compliance activity.
  - Reactive activity volumes
  - Completed projects (pro-active activity)

- Action: Receive and File

Reactive Issue Count by Fiscal Year

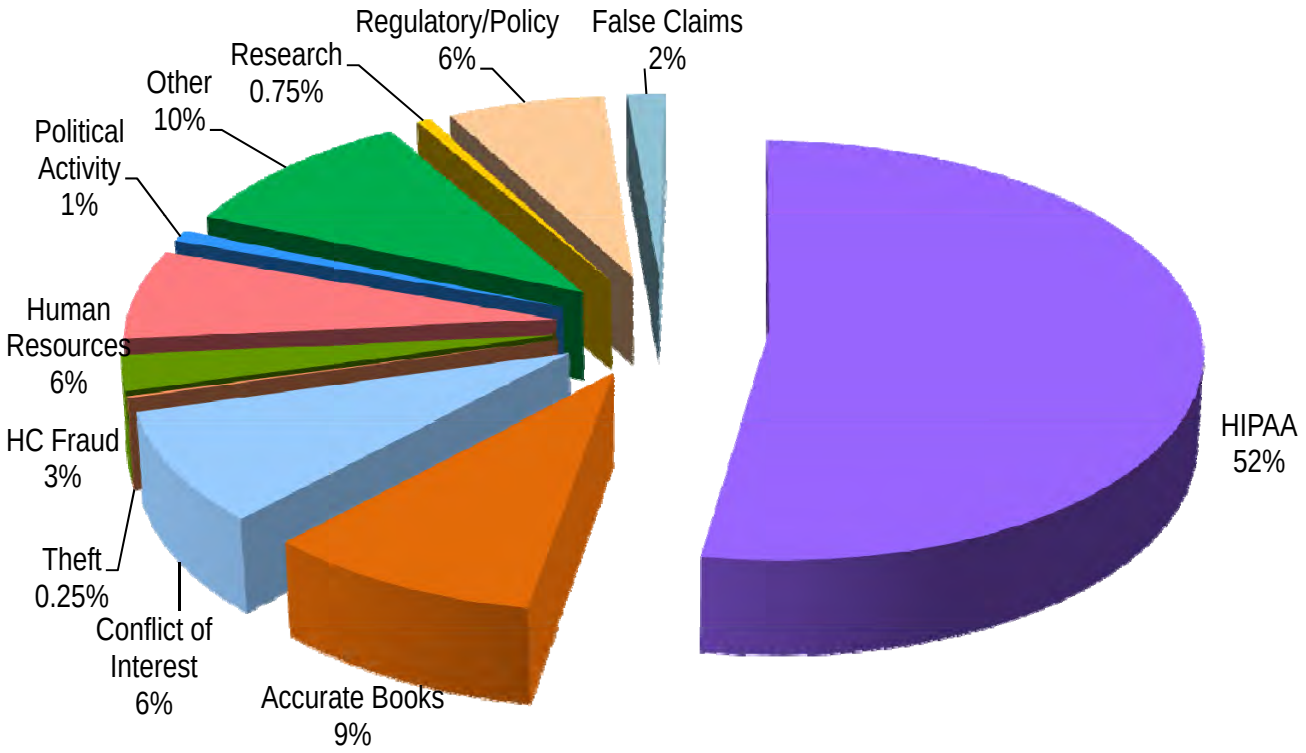


Actual Reactive Issue Activity



2014 Issue Breakdown by Category

671[1] Reactive Corporate Compliance Issues Were Raised



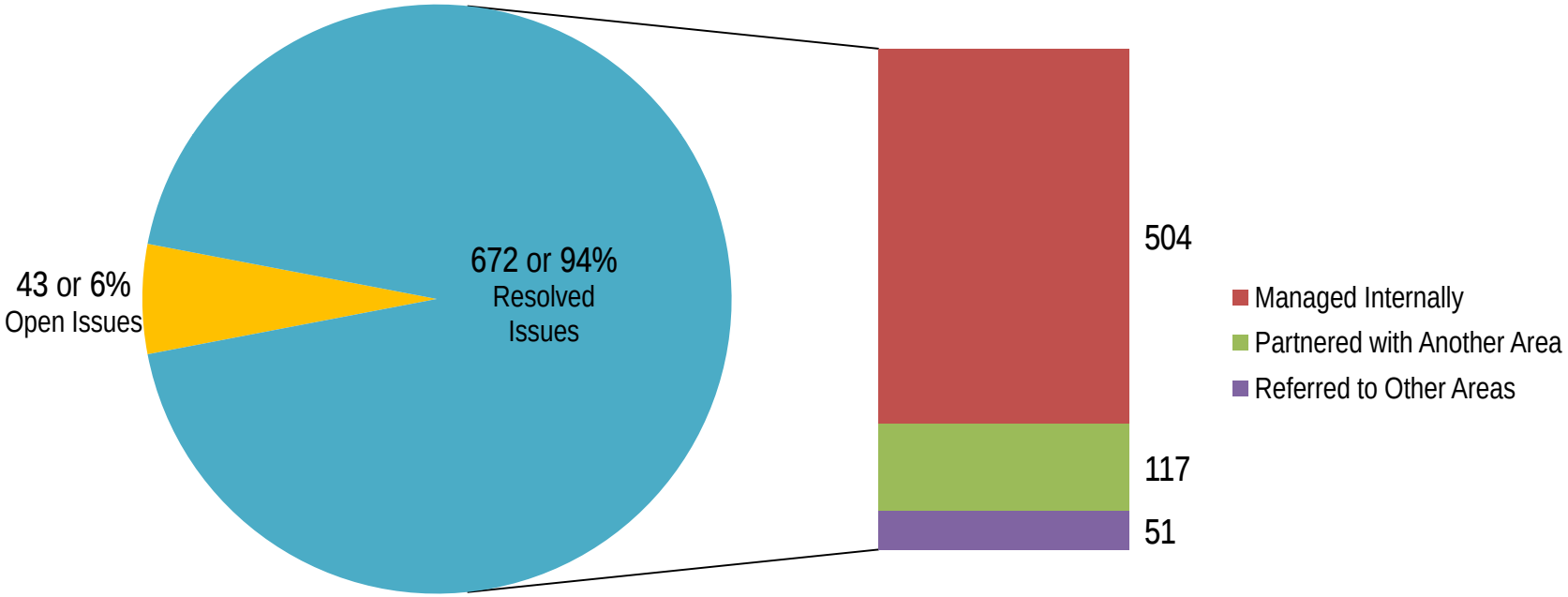
Category Count[1]

Privacy (HIPAA)	362	Human Resources	48	Political Activity	6	Regulatory/Policy	45
Accurate Books	65	HC Fraud	19	Research	4	Other	71
Conflict of Interest	59	False Claims	11	Theft	1		

[1] This is a total count of the issues raised to Corporate Compliance. Not all issues are validated/substantiated.

Status Report of Issues

Of the total number of reactive issues addressed during FY 2014, 6% or 43 issues remained open at close of the fiscal year.



The majority of the issues, 92%, were either managed solely by Corporate Compliance or Corporate Compliance partnered with another area to address the concern raised.

FY 2014 Projects

- CountyCare
  - Established a Corporate Compliance Program to demonstrate commitment to promoting ethical and lawful conduct consistent with all applicable laws, regulations, and contractual requirements, as well as CCHHS policies, procedures, and Code of Ethics/Standards of Conduct.
  - Developed Compliance Plan
- 340B Compliance
  - Partnered with operational areas to develop policy and corresponding procedures to document compliance.
- External DRG Probe Audit
  - Reviewed a random sample of the top DRG's at both John H. Stroger, Jr. Hospital and Provident Hospital. Deficiencies noted, coders reeducated, and corrective action plan includes ongoing monitoring.
- Teaching Physician Attestation with Primary Care Exception
  - Assessed current process and researched Medicare Requirements. Facilitated meetings with Physician Leadership, created Policies and Procedures, and assisted in implementation.
- Identity Theft
  - Partnered with operations to create policies and procedures; developed a consistent approach to remedy the impact of identity theft on operations.

Projects *(continued)*

- Medical Records
  - Assisted with policies and procedures for release of information and amending medical records. Updated release of information authorization forms.
- Record Retention
  - Developed retention matrix, which will supplement the existing policy and provide retention guidance to the System using the Illinois Hospital Association's Record Retention Reference and the current retention material filed with the state of Illinois.
- Education
  - Developed compliance focused modules for annual education for the CCHHS workforce.
  - Managed the ongoing operations and day-to-day management of the CCHHS electronic learning management system (LMS) for all organizational training.
- Conflict of Interest
  - For all employees: Developed a Dual Employment eForm.
  - For those with decision-making responsibilities: Accounting of Disclosures.
  - Managed Processes for both.

ATTACHMENT #5

CCHHS Compliance Program Operation Plan

The CCHHS Operation Plan,

- Summarizes the essence of the CCHHS Compliance Program
- Demonstrates the organization's commitment to promoting ethical and lawful conduct consistent with all applicable laws, regulations, and contractual requirements, as well as CCHHS policies, procedures, and Code of Ethics/ Standards of Conduct.
- Parallels the elements of an effective compliance program as recommended through Federal Sentencing Guidelines and the HHS Office of Inspector General Compliance Program Guidance publications and is required by the CMS Managed Care Program Integrity requirements.
- Originally approved in April 2010.

- Action: Review and Approve

Corporate Compliance Program

Insert Date of Adoption
Cook County Health and Hospital Systems

PROGRAM LEAD:

Cathy Bodnar, MS, RN, CHC
Chief Compliance and Privacy Officer
Cook County Health & Hospitals System

APPROVAL PARTIES:

Audit & Compliance Committee of the Cook County Health & Hospitals System Board of Directors
Originally Approved on July 16, 2010
Reviewed and Approved on <<insert date>>

Jay Shannon, MD
Chief Executive Officer
Cook County Health & Hospitals System
Electronically Approved on <<insert date>>

Table of Contents

1.0 Introduction

The Cook County Health & Hospitals System (CCHHS) is the public, safety-net health care system for Chicago and suburban Cook County. John H. Stroger, Jr. Hospital (Stroger), CCCHHS' academic medical center, is located in the Illinois Medical District on Chicago's Near West Side and primarily serves the acute care needs of the people of metropolitan Chicago. The System is also comprised of Provident Hospital on Chicago's South Side and the Oak Forest Health Center in suburban Oak Forest, along with the Ruth M. Rothstein CORE Center in addition to multiple Ambulatory and Community Health Network clinics. Healthcare is also provided within Cermak Health Services of Cook County, to detainees at the Cook County Jail and the Temporary Juvenile Detention Center, and the Cook County Department of Public Health. CCHHS also operates CountyCare, a Managed Care Community Network ("MCCN") plan pursuant to a contract with the Illinois Department of Healthcare and Family Services ("HFS"). CountyCare is designed to provide coverage for currently uninsured individuals and transform CCHHS into a patient-centered continuum of care.

2.0 Purpose

It is the policy of CCHHS and all affiliated organizations (collectively, "CCHHS") to establish and support a system-wide Corporate Compliance Program. CCHHS is committed to conducting business in a manner that is ethical and in compliance with all applicable federal, state and local laws. To that end, the Cook County Health & Hospitals System Board of Directors, through the Audit and Compliance Committee of the Board, established and continues to maintain a Corporate Compliance Program.

The Corporate Compliance Program is designed to demonstrate the organization's commitment to promoting ethical and lawful conduct consistent with all applicable laws, regulations, and contractual requirements, as well as CCHHS policies, procedures, and Code of Ethics/Standards of Conduct. The Corporate Compliance Program is structured around the elements of an effective compliance program as recommended in the Federal Sentencing Guidelines and the Department of Health and Human Services ("HHS") Office of Inspector General ("OIG") Compliance Program Guidance publications and required by the Centers for Medicare & Medicaid Services ("CMS") Managed Care Program Integrity requirements found at 42 C.F.R. §438.608.

3.0 Definitions

Abuse means (i) a manner of operation that results in excessive or unreasonable costs to the Federal or State health care programs, generally used in conjunction with Fraud; or (ii) the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, generally used in conjugation with Neglect.

Business Associate means a third party engaged to perform work on behalf of CCHHS.

CCHHS Personnel includes officers, directors, members of committees with Board-delegated authority, employees, volunteers and members of the medical staff or house staff, researchers, students, and other personnel working under the direction of CCHHS.

Chief Compliance Officer is the CCHHS Chief Compliance and Privacy Officer or his/her staff as designated by the Chief Compliance Officer.

Fraud means knowing and willful deception, or a reckless disregard of the facts, with the intent to receive an unauthorized benefit.

Plan Member means an individual who is enrolled in the CountyCare health plan.

4.0 Corporate Compliance Program Overview

The Corporate Compliance Program upholds the mission, vision, and core goals of CCHHS by establishing and supporting a system-wide culture of honesty and respect to guide everyone's actions by developing standards, increasing awareness and promoting honest behavior and professional responsibility through education, awareness, and shared accountability that promotes compliance with applicable laws, regulations, and system policies. In addition, the Corporate Compliance Program is designed to prevent and detect violations of applicable laws and regulations, CCHHS Code of Ethics, and organizational policies.

The Corporate Compliance Program applies to all affiliates and business units of CCHHS, both the health care provider side and the CountyCare plan side, and to all Business Associates and contractors associated with CCHHS. While it is expected that CCHHS personnel will comply with applicable laws and regulations, the CCHHS Code of Ethicsand policies, CCHHS management and directors understand that the implementation of the Corporate Compliance Program cannot eliminate all risk of improper conduct. In the event that CCHHS becomes aware of possible violations of law or the Code of Ethics or policies, the Chief Compliance Officer will investigate the matter with management and, where appropriate, act as a resource for Human Resources regarding recommended disciplinary action to deter future violations. Where appropriate, the Chief Compliance Officer will confer with legal counsel.

The Chief Compliance and Privacy Officer, in consultation with Senior Leadership, the Compliance Oversight Committee, and the CCHHS Board of Directors, through the Audit & Compliance Committee of the Board of Directors, are responsible for coordinating the implementation of the CCHHS Corporate Compliance Program. The Corporate Compliance Program is subject to ongoing review and revision as deemed necessary to ensure compliance. It is designed to accommodate future changes in regulations and laws and may be updated to address issues not currently covered or issues related to new service offerings or regulatory requirements.

The sections below establish the scope of activities, authority, reporting, committee and governance structure, and assessment guidelines for the CCHHS Corporate Compliance Program.

5.0 Scope of Activities for the Corporate Compliance Program

The Corporate Compliance Program incorporates professional ethics and responsibility and regulatory compliance. This includes, but is not limited to, the prevention or correction of potential violations falling within the following categories, as well as adherence to the CCHHS Standards of Conduct (Code of Ethics) and organizational policies:

- Accurate Books and Records
- Anti-kickback **activities**

- CMS Managed Care Program Integrity requirements
- Conflict of Interest
- Emergency Medical Treatment and Labor Act (EMTALA)
- False Claims
- Financial Integrity
- Fraud, Bribery, and Theft
- Integrity in both Marketing and Purchasing Practices
- Patient Privacy, Confidentiality, and Security (HIPAA)
- Research, Clinical Trials, and Grant Compliance
- Undue Political Activity and Operational Influence

6.0 Corporate Compliance Program Elements

The Corporate Compliance Program incorporates the seven elements of an effective compliance program, as suggested by the HHS OIG and as mandated by the CMS Managed Care Program Integrity requirements. It includes the following specific controls to ensure CCHHS meets all federal, state, and contractual requirements. Elements of the Corporate Compliance Program include:

1. **Written Policies, Procedures and Code of Ethics.** CCHHS has a uniform Code of Ethics that provides policies and guidelines for all CCHHS personnel. The CCHHS Code of Ethics applies to all CCHHS personnel, providers, agents and subcontractors. The Standards of Conduct, as well as CCHHS's policies and procedures, support the organization's commitment to comply with all federal and state standards, including but not limited to, applicable statutes, regulations and sub-regulatory guidance and contractual requirements.

   The Code of Ethics will be distributed to CCHHS personnel and updated as necessary. Training on the Code of Ethics will be included in the new hire orientation program. Staff will be asked to attest to receiving the Code. The Code will also be available on the CCHHS Intranet.

   The Chief Compliance and Privacy Officer will regularly review the Code of Ethics to assure that it covers significant risks caused by changing regulation and practices. Recommendations for changes to the Code of Ethics will be forwarded to the Chief Executive Officer and to the Audit & Compliance Committee of the Board of Directors, which has the authority to change the Code of Ethics and inform CCHHS personnel of these changes.

   Additionally, CCHHS personnel, providers, agents and subcontractors have access to compliance documentation via the CCHHS intranet portal and are provided with copies of compliance policies and procedures, upon request. CCHHS Corporate Compliance Program policies and procedures address the following subject areas:
   - Corporate Compliance Mission and Vision Statement; and
   - Corporate Compliance Program operations, including:
     - Position Descriptions
     - Board, Committee and Subcommittee Charter Statements
     - New Employee and Annual Training
     - Compliance Hotline and Methods for Communication
     - Excluded Providers Sanction Screening

- Compliance Reporting and Non Retaliation
- Compliance Auditing and Monitoring
- Compliance Investigations.

2. **Chief Compliance Officer.** The Chief Compliance and Privacy Officer, and her designees, oversee and are ultimately responsible for developing, assessing, and administering the Corporate Compliance Program. The Chief Compliance and Privacy Officer reports and is accountable to the CCHHS Chief Executive Officer (CEO) and the CCHHS Board of Directors, through the Audit & Compliance Committee of the Board.

   The Chief Compliance and Privacy Officer, and her designees, are responsible for:
   - Serving as an internal consultant and resource for compliance matters;
   - Overseeing and monitoring the ongoing functions of the Corporate Compliance Program, including the overall operations of the CountyCare Compliance Plan;
   - Participating in regular, CCHHS-wide risk assessments to understand potential vulnerabilities
   - Serving as the Privacy Officer for CCHHS to assure compliance with HIPAA and applicable State laws regarding protection of patient health information;
   - Reporting on a regular basis to the CCHHS governing bodies;
   - Periodically revising the Corporate Compliance Program, with input from the Audit & Compliance Committee of the Board of Directors and Executive Management, in light of changes directed to the needs of CCHHS and applicable laws and policies of federal, state, and local government bodies;
   - Developing, coordinating and participating in training programs that focus on the elements of the Corporate Compliance Program and providing training such that workforce members are knowledgeable of and comply with the Code of Ethics, compliance policies, laws and regulations;
   - Coordinating and overseeing compliance auditing and monitoring activities;
   - Responding to reports of issues or suspected violations related to compliance by independently investigating these matters or, as appropriate, working with department managers, Human Resources, and General Counsel in the determination of corrective action that must be taken;
   - Assuring, through consultation with Human Resources and General Counsel, that the CCHHS disciplinary policies and actions are applied fairly, equitably, appropriately, and consistently; and
   - Developing policies and programs that encourage CCHHS personnel to report suspected fraud and other improprieties without fear of retaliation or retribution.

3. **Effective Training and Education.** Initial and continuing education of CCHHS personnel, agents, and subcontractors is a significant element of Corporate Compliance Program. Applicable personnel, agents, and subcontractors receive training at hire/contract initiation and annually thereafter on their responsibilities under the Corporate Compliance Program, the CCHHS Code of Ethics and the HIPAA Privacy and Security, and how to prevent, identify, and report fraud, abuse, and misconduct. CountyCare will also provide task oriented and job-specific compliance training to personnel, agents, providers and subcontractors on an as needed basis.

There are policies and procedures in place to ensure that all personnel, agents, and subcontractors complete training as mandated by regulatory and contractual obligations. Completion of training is documented and maintained, as are the training materials used.

4. **Effective Lines of Communication.** CCHHS has implemented clear policies and procedures for reporting concerns related to compliance, integrity, and fraud, abuse, and misconduct. All personnel, agents, and subcontractors have a duty to report misconduct including actual or potential violations of law, regulation, policy, procedure or the CCHHS Code of Ethics to their supervisor, another member of management, Human Resources or the Chief Compliance and Privacy Officer. Failure to report a violation may result in appropriate disciplinary action. Personnel, agents, and subcontractors are protected from retaliation and harassment as a result of having reported a good faith compliance or integrity concern. CCHHS maintains procedures for reporting instances of suspected fraud, abuse, or financial misconduct to HFS and OIG. Additionally, CCHHS makes regular communications to its employees and subcontractors regarding compliance information and updates.

   Communication mechanisms utilized by CCHHS include:
   - CCHHS Corporate Compliance Hot Line (operating 24 hours a day/7 days a week);
   - CountyCare Member Services Call Center;
   - CountyCare Fraud, Waste and Abuse Hotline; and
   - Compliance plan communications, including emails, flyers, posters, newsletters, and emails to CCHHS personnel, contractors and CountyCare plan members regarding compliance efforts and initiatives.

5. **Well-Publicized Disciplinary Standards.** All personnel, agents, providers and subcontractors are informed that violations of the Corporate Compliance Program, Code of Ethics or policies and procedures will result in appropriate disciplinary action or sanctions. For CCHHS personnel, this could mean up to and including termination of employment. Contracts with agents, providers and subcontractors contain provisions regarding the organization's responsibility for adhering to CCHHS contractual requirements and applicable state and federal regulations. Non-compliance may result in termination of the contractual relationship with CCHHS, where applicable.

6. **Monitoring and Auditing.** CCHHS has implemented a monitoring and auditing program which includes written policies and procedures for routine internal monitoring as well as oversight auditing by the CCHHS Office of Corporate Compliance. The monitoring and auditing program tests and confirms compliance with regulatory guidance, contractual agreements, and applicable federal and state laws, as well as internal policies and procedures to protect against non-compliance and potential fraud, abuse, and financial misconduct. Additionally, regular audits of subcontractors and agents are conducted to ensure compliance with contractual and regulatory requirements. Auditing and monitoring activity is conducted in accordance with the annual Compliance Work Plan, developed by the Chief Compliance and Privacy Officer, with input from the CCHHS Board of Directors, through the Audit and Compliance Committee of the Board. Results of monitoring and auditing activities, and subsequent corrective action plans, are reported to the CCHHS Board of Directors, through the Audit and Compliance Committee of the Board.

7. **Prompt Response to Detected Offenses.** CCHHS has established and implemented methods and programs that encourage personnel and subcontractors to report program non-compliance and potential fraud and abuse or financial misconduct without fear of retaliation. This includes a process

consistent with state requirements for responding to reports of potential fraud and abuse or misconduct, including reporting such instances to the HFS and HHS OIGs, cooperating with OIG investigations, and developing and implementing appropriate corrective or disciplinary actions, if necessary.

7.0 Program Authority and Reporting

The Chief Compliance and Privacy Officer reports to the Audit & Compliance Committee of the Board of Directors and to the CCHHS Chief Executive Officer.

The Audit & Compliance Committee of the Board of Directors has the responsibility for the Corporate Compliance Program for all CCHHS affiliates. The Committee, composed of independent directors, provides oversight to the CCHHS Corporate Compliance Program. The Committee advises the Board regarding the implementation of standards and processes to assure professional responsibility and honest behavior, identification of areas of potential compliance vulnerability and risk, and compliance with regulatory requirements.

The Chief Compliance and Privacy Officer reports regularly to the Audit & Compliance Committee. The reports to the Committee may include the following:

- The annual compliance work plan, including the auditing and monitoring plan and priorities;
- Summaries of ongoing auditing and monitoring activities of the Corporate Compliance Office, including tracking of recommendations and corrective actions;
- Results of specific compliance audits conducted by or on behalf of the Corporate Compliance Program;
- Summaries of calls received by the Compliance Hot Line and remediation efforts;
- Summaries of investigations conducted by the Corporate Compliance Office and results/remediation;
- Areas of compliance risk, including patient privacy and confidentiality;
- Information regarding the results of any governmental audits, investigations, or activities undertaken at CCHHS;
- Education for the Audit & Compliance Committee on topics related to Compliance, Privacy, or new regulatory initiatives affecting CCHHS; and/or
- Discussions of specific topics that are potential areas of compliance vulnerability and risk.

Reports that concern subject matter which meets an applicable exception under the Open Meetings Act (5 ILCS 120(2)) will be provided in a closed meeting forum, with such meeting closed in accordance with Section 2(a) of the Closed Meeting Act (5 ILCS 120/2a).

The Chief Compliance and Privacy Officer has the authority to access and review all documentation and other information that is relevant to CCHHS compliance activities, including, but not limited to, patient records, billing records, employee records, computer audit files, and arrangements between the hospitals and other parties, including employees, professionals on staff, independent contractors, suppliers, agents and physicians.

8.0 Periodic Program Assessment

The Corporate Compliance Program will be assessed internally, on an ongoing basis, or at a minimum once per year. An assessment by an outside consultant shall occur every 3 to 5 years to assure that the Corporate Compliance Program is current, accurately assesses the risk areas facing CCHHS, and devotes the appropriate amount of resources required to provide an effective compliance program.

9.0 Reporting Compliance Concerns

CCHHS supports a safe, non-threatening environment where individuals may ask questions about integrity and compliance, fraud, abuse and financial misconduct matters and report their concerns. As part of the CCHHS commitment to mission and core values, anyone who has a concern has an opportunity to report those concerns confidentially and without fear of retaliation. Concerns may be submitted in a number of different ways, including to the CCHHS Corporate Compliance Hotline at **1-866-489-4949.**

CCHHS encourages personnel to first speak with their manager or supervisor about any concerns. If they are uncomfortable or unsure about how to do this, CCHHS Office of Corporate Compliance staff members are available to help.

Those who report compliance concerns are protected from retaliation and harassment. Concerns about possible retaliation or harassment stemming from a compliance report may be reported to the Chief Compliance and Privacy Officer, or human resources personnel.

ATTACHMENT #6

CountyCare Compliance Plan

The CountyCare Compliance Plan,

- Summarizes the CountyCare Compliance Plan, as required by the Managed Care Community Network (MCCN) Contract with the Department of Healthcare and Family Services (HFS).
- Parallels the elements of an effective compliance program recommended through Federal Sentencing Guidelines and Compliance Program Guidance and is required by CMS Managed Care Program Integrity requirements. The CountyCare Compliance Plan also contains additional information regarding CountyCare procedures to prevent and detect fraud, waste and abuse and manage grievances and appeals.
- The CountyCare Compliance Plan will be managed and maintained by the CCHHS Office of Corporate Compliance, in collaboration with the Third Party Administrator, IlliniCare.

- Action: Review and Approve

CountyCare Compliance Plan

Insert Date of Adoption

PROGRAM LEAD:

Cathy Bodnar, MS, RN, CHC
Chief Compliance and Privacy Officer
Cook County Health & Hospitals System

APPROVAL PARTIES:

Audit & Compliance Committee of the Cook County Health & Hospitals System Board of Directors
Approved on <<insert date>>

John Jay Shannon, MD
Chief Executive Officer
Cook County Health & Hospitals System
Electronically Approved on January 30, 2015

Table of Contents

1.0 Introduction

CountyCare is a Managed Care Community Network ("MCCN") plan offered by Cook County Health and Hospitals System ("CCHHS") pursuant to a contract with the Illinois Department of Healthcare and Family Services ("HFS"). CountyCare is designed to provide coverage for any Cook County Medicaid eligible beneficiaries and transform CCHHS into a patient-centered continuum of care. The operation of the CountyCare MCCN is facilitated through CCHHS and its various subcontractors. All personnel tasked with CountyCare operational responsibilities are CCHHS personnel or subcontractors, agents and non-CCHHS providers.

As an integral part of CCHHS, CountyCare will uphold the mission, vision, and core goals of the system by establishing and supporting a system-wide culture of honesty and respect to guide individual's actions by developing standards, increasing awareness, and promoting honest behavior and professional responsibility through education, awareness, and shared accountability that promotes compliance with applicable laws, regulations, and system policies.

CountyCare has developed this CountyCare Compliance Plan to demonstrate its commitment to promoting ethical and lawful conduct consistent with all applicable laws, regulations, and contractual requirements, as well as CCHHS policies, procedures, and Code of Ethics/Standards of Conduct. The CountyCare Compliance Plan is structured around the elements of an effective compliance program as recommended in the Department of Health and Human Services Office of Inspector General ("OIG") Compliance Program Guidance publications and required by the Centers for Medicare & Medicaid Services ("CMS") Managed Care Program Integrity requirements found at 42 C.F.R. §438.608. Upon implementation, the CountyCare Compliance Plan will be managed and maintained by the CCHHS Office of Corporate Compliance.

2.0 Purpose

All personnel are expected to uphold honest and ethical behavior, comply with laws, regulations, and system policies, and to fulfill their responsibilities as important members of the CCHHS organization. In order to preserve this environment, all personnel, agents, providers, and subcontractors are expected to demonstrate the highest ethical standards in performing their daily tasks. The purpose of the CountyCare Compliance Plan is to communicate the compliance expectations to all CountyCare stakeholders, including those related to the prevention and detection of fraud, abuse, and financial misconduct within plan operations. This communication is intended to reduce the likelihood of improper conduct within the CountyCare organization and among its many stakeholders.

Further, the CountyCare Compliance Plan outlines guidelines to:

- Comply with the CMS Managed Care Program Integrity requirements and the terms of the CountyCare Health Plan contract with HFS;
- Prevent, detect and eliminate fraud, abuse, and financial misconduct;
- Protect health plan members, providers, CountyCare and the State from potential fraudulent activities; and
- Understand and focus on high-risk areas that have the greatest potential for non-compliance with federal and state regulatory and contractual requirements.

3.0 Definitions and Abbreviations

Abuse means (i) a manner of operation that results in excessive or unreasonable costs to the Federal or State health care programs, generally used in conjunction with Fraud; or (ii) the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, generally used in conjugation with Neglect.

Centers for Medicare & Medicaid Services (CMS) means the agency within DHHS that is responsible for the administration of the Medicare program and, in partnership with the states, administers Medicaid, the State Children's Health Insurance Program (SCHIP), and the Health Insurance Portability and Accountability Act (HIPAA).

DHHS means the United States Department of Health and Human Services.

DHS means the Illinois Department of Human Services, and any successor agency.

DHS-OIG means the Department of Human Services Office of Inspector General that is the entity responsible for investigating allegations of Abuse and Neglect of people who receive Mental Health or Developmental Disabilities services in Illinois and for seeking ways to prevent such Abuse and Neglect.

Fraud means knowing and willful deception, or a reckless disregard of the facts, with the intent to receive an unauthorized benefit.

HFS means the Illinois Department of Healthcare and Family Services and any successor agency (may also be referred to as "Agency" or "the Department").

Health Plan means a delivery system of coordinated services that a Potential Enrollee or Enrollee may select or be assigned to for health care, as implemented by the Department. A Health Plan includes delivery systems such as a HMO, MCCN, Care Coordination Entity and Accountable Care Entity**.**

Managed Care Organization (MCO) means an entity that meets the definition of managed care organization as defined at 42 CFR 438.2 and that has a contract with the Department to provide Covered Services under the Medicaid Program. It includes a Managed Care Community Network (MCCN), including the County MCCN operated by CountyCare, and may also include another such entity with a contract with the Department to provide Covered Services in the Contracting Area.

Mandated Reporting means immediate reporting required from a mandated reporter of suspected maltreatment when the mandated reporter has reasonable cause to believe that an individual known to the mandated reporter in a professional or official capacity may be Abused or Neglected.

Office of Inspector General (OIG) means the Office of Inspector General for the Department as set forth in 305 ILCS 5/12-13.1.

Personnel includes CCHHS employees, medical staff, house staff, research staff, Board members, Board appointed committee members, volunteers, students, consultants, agency personnel, and vendors.

Plan Member means a Participant who is enrolled in the CountyCare Health Plan.

Provider means a Person enrolled with the Department to provide Covered Services to CountyCare plan members.

State means the State of Illinois, as represented through any State agency, department, board, or commission.

Subcontractor means an entity, including a Provider, with which CountyCare has entered into a written agreement for the purpose of delegating responsibilities applicable to CountyCare.

4.0 CountyCare Compliance Plan Overview

The Chief Compliance and Privacy Officer, in consultation with Senior Leadership, the Compliance Oversight Committee, and the CCHHS Board of Directors, through the Audit & Compliance Committee of the Board of Directors, are responsible for coordinating the implementation of the CountyCare Compliance Plan. The CountyCare Compliance Plan is subject to ongoing review and revision as deemed necessary to ensure compliance. It is designed to accommodate future changes in regulations and laws and may be updated to address issues not currently covered or issues related to new service offerings or regulatory requirements.

5.0 CountyCare Compliance Plan Elements

CountyCare's Compliance Plan incorporates the seven elements of an effective compliance program as mandated by the CMS Managed Care Program Integrity requirements. It includes the following specific controls to ensure CountyCare meets all federal, state, and contractual requirements. Elements of CountyCare's Compliance Plan include:

1. **Written Policies, Procedures and Standards of Conduct.** The CCHHS Standards of Conduct applies to all CountyCare personnel, providers, agents and subcontractors. The Standards of Conduct, as well as CCHHS's policies and procedures, support CountyCare's commitment to comply with all federal and state standards, including but not limited to, applicable statutes, regulations and sub-regulatory guidance and contractual requirements.

   CountyCare personnel, providers, agents and subcontractors have access to compliance documentation via the CCHHS intranet portal and are provided with copies of compliance policies and procedures, upon request. CountyCare compliance policies and procedures address the following subject areas:
   - Standards of Conduct/Code of Ethics
   - Corporate Compliance Mission and Vision Statement
   - Compliance Program operations, including:
     - Position Descriptions
     - Board, Committee and Subcommittee Charter Statements
     - New Employee and Annual Training
     - Compliance Hotline and Methods for Communication
     - Excluded Providers Sanction Screening
     - Compliance Reporting and Non Retaliation
     - Compliance Auditing and Monitoring
     - Compliance Investigations
   - Fraud, Waste, Abuse and Financial Misconduct
   - Cultural Competency
   - Conflict of Interest

2. **Compliance Officer and Compliance Oversight Committee.** The CCHHS Chief Compliance and Privacy Officer, CCHHS Compliance Officer assigned to CountyCare, and their designees, oversee and are ultimately responsible for developing, assessing, and administering the CountyCare Compliance Plan. The CCHHS Chief Compliance Privacy Officer reports and is accountable to the CCHHS Chief Executive Officer (CEO) and the CCHHS Board of Directors, through the Audit & Compliance Committee of the Board.

   The CCHHS Chief Compliance and Privacy Officer, and her designees, are responsible for:
   - Overseeing the CountyCare Compliance Plan;
   - Managing the complaint, grievance and fair hearing process;
   - Serving as the primary liaison with HFS to facilitate communications between HFS and CountyCare executive leadership and staff; and
   - Ensuring and verifying the fraud and abuse is reported in accordance with regulatory requirements.

   The CountyCare Compliance Oversight Committee is tasked with general oversight of the CountyCare Compliance Plan operations and overall support of the CountyCare culture of compliance. Specifically, the CountyCare Compliance Oversight Committee is responsible for:
   - Overseeing the implementation of CountyCare Compliance Plan;
   - Providing oversight and guidance regarding CountyCare operations to fulfill Compliance program requirements and monitor corrective action plans as necessary;
   - Meeting on a monthly basis, and as needed;
   - Appointing a liaison to HFS to report potential fraud, abuse, or financial misconduct;
   - Ensuring compliance with quarterly COUNTYCARE HEALTH PLAN fraud, abuse or financial misconduct reporting requirements; and
   - Reporting to CCHHS Board of Directors, through the Audit & Compliance Committee of the Board, and the CEO.

3. **Effective Training and Education.** Initial and continuing education of personnel, agents, providers and subcontractors is a significant element of CountyCare's Compliance Plan. Applicable personnel, agents, providers and subcontractors receive training at hire/contract initiation and annually thereafter on their responsibilities under the CountyCare Compliance Plan, the CCHHS Standards of Conduct/ Code of Ethics, the CountyCare Cultural Competency Plan, HIPAA Privacy and Security, and how to prevent, identify, and report fraud, abuse, and financial misconduct. CountyCare will also provide task oriented and job-specific compliance training to personnel, agents, providers and subcontractors on an as needed basis.

   There are policies and procedures in place to ensure that all personnel, agents, providers and subcontractors complete training as mandated by regulatory and contractual obligations. Completion of training is documented and maintained, as are the training materials used.

4. **Effective Lines of Communication.** CountyCare has implemented clear policies and procedures for reporting concerns related to compliance, integrity, and fraud, abuse, and financial misconduct. All personnel, agents, providers and subcontractors have a duty to report misconduct including actual or potential violations of law, regulation, policy, procedure or the CCHHS Standards of Conduct/Code of Ethics to their supervisor, another member of management, Human Resources or

the Chief Compliance and Privacy Officer. Failure to report a violation may result in appropriate disciplinary action. Personnel, agents, providers and subcontractors are protected from retaliation and harassment as a result of having reported a good faith compliance or integrity concern. CountyCare maintains procedures for reporting instances of suspected fraud, abuse, or financial misconduct to HFS and OIG. Additionally, CCHHS makes regular communications to its employees and subcontractors regarding compliance information and updates.

Communication mechanisms utilized by CountyCare include:

- CCHHS Corporate Compliance Hot Line (operating 24 hours a day/7 days a week)
- CountyCare Member Services Call Center
- CountyCare Fraud, Waste and Abuse Hotline
- CountyCare Compliance Plan communications, including emails, flyers, posters, newsletters, and emails to CountyCare employees, contractors and members regarding compliance efforts and initiatives.

5. **Well-Publicized Disciplinary Standards.** All personnel, agents, providers and subcontractors are informed that violations of the CountyCare Compliance Plan, Standards of Conduct/Code of Ethics or policies and procedures will result in appropriate disciplinary action or sanctions. For CountyCare personnel, this could mean up to and including termination of employment. Contracts with agents, providers and subcontractors contain provisions regarding the organization's responsibility for adhering to CountyCare contractual requirements and applicable state and federal regulations. Non-compliance may result in termination of the contractual relationship with CountyCare and CCHHS, where applicable.

6. **Monitoring and Auditing.** CountyCare has implemented a monitoring and auditing program which includes written policies and procedures for routine internal monitoring as well as oversight auditing by the CCHHS Office of Corporate Compliance. The monitoring and auditing program tests and confirms compliance with CMS and HFS managed care requirements, regulatory guidance, contractual agreements, and applicable federal and state laws, as well as internal policies and procedures to protect against non-compliance and potential fraud, abuse, and financial misconduct. Additionally, regular audits of subcontractors, agents and providers are conducted to ensure compliance with contractual and regulatory requirements. Auditing and monitoring activity is conducted in accordance with the annual Compliance Work Plan, developed and approved by the CountyCare Compliance Oversight Committee, with input from the CCHHS Board of Directors, through the Audit and Compliance Committee of the Board. Results of monitoring and auditing activities, and subsequent corrective action plans, are reported to the CountyCare Compliance Oversight Committee and the CCHHS Board of Directors, through the Audit and Compliance Committee of the Board.

7. **Prompt Response to Detected Offenses.** CountyCare has established and implemented methods and programs that encourage personnel and subcontractors to report program non-compliance and potential fraud and abuse or financial misconduct without fear of retaliation. This includes a process consistent with HFS contractual requirements for responding to reports of potential fraud and abuse or financial misconduct, including reporting such instances to the OIG, cooperating with OIG investigations, and developing and implementing appropriate corrective or disciplinary actions, if necessary.

6.0 Reporting Compliance Concerns

CountyCare supports a safe, non-threatening environment where individuals may ask questions about integrity and compliance, fraud, abuse and financial misconduct matters and report their concerns. As part of the CountyCare commitment to mission and core values, anyone who has a concern has an opportunity to report those concerns confidentially and without fear of retaliation. Concerns may be submitted in a number of different ways which include:

- CountyCare Member Services Call Center: **1-312-864-8200**
- CountyCare Fraud, Waste and Abuse Hotline: **1-866-685-8664**
- CCHHS Corporate Compliance Hotline: **1-866-489-4949**

CountyCare encourages personnel to first speak with their manager or supervisor about any concerns. If they are uncomfortable or unsure about how to do this, CCHHS Office of Corporate Compliance staff members are available to help.

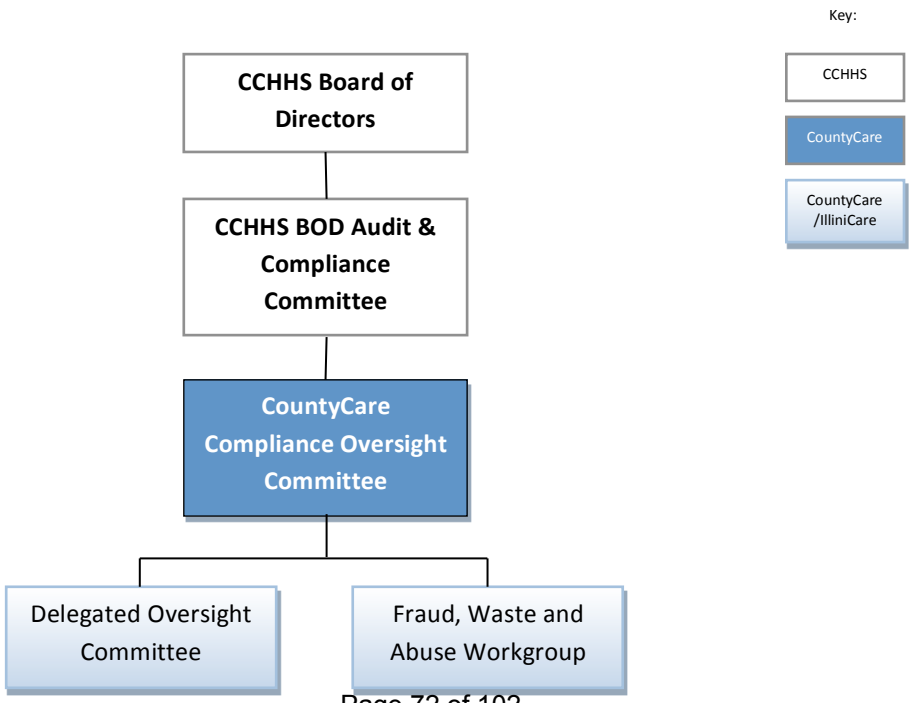
Those who report compliance concerns are protected from retaliation and harassment. Concerns about possible retaliation or harassment stemming from a compliance report may be reported to the Chief Compliance and Privacy Officer, or human resources personnel.

7.0 Fraud and Abuse Procedures

CountyCare is dedicated to preventing, detecting and reporting health care fraud, waste, abuse and financial misconduct, as is required by federal and state statutory, regulatory and contractual obligations. As such, there are multiple processes and procedures in place to prevent, detect, investigate and report, as necessary, suspected instances of Fraud, Abuse or financial misconduct involved in CountyCare operations. Additionally, where these instances arise, CountyCare has an affirmative contractual obligation to report this information to the HFS OIG.

Fraud and Abuse Oversight Structure

Below is an organization chart outlining the oversight structure for fraud and abuse monitoring and reporting activities.



Fraud and Abuse Monitoring Procedures

CountyCare, in coordination with its CountyCare Third Party Administrator (TPA), have developed and implemented the following fraud and abuse procedures:

- All CountyCare personnel, agents, providers, and subcontractors are contractually required to report any instances of suspected or actual fraud, abuse or financial misconduct.
- Payment Integrity (PI) efforts dedicated to detecting, preventing and recovering potential Fraud Waste and Abuse payments, including claims edits and post-processing review of claims. *(See CountyCare Fraud, Waste and Abuse Plan for more detail).*
- Special Investigation Units (SIU) operations to identify, investigate, remediate and report instances of Fraud Waste and Abuse, as required by the COUNTYCARE HEALTH PLAN agreement and the state. *(See CountyCare Fraud, Waste and Abuse Plan for more detail).*
- Explanation of Benefits (EOB) Service Verification notices are sent to members to identify to identify phantom providers or services that were not performed.
- Fraud, Waste and Abuse training is provided for all personnel, agents, subcontractors and providers to explain the procedures for reporting, as well as provide background information and examples of possible fraud, abuse or financial misconduct.
- Provider credentialing processes ensure that all providers have a Medicaid Provider Number and meet credentialing guidelines established by CountyCare prior to providing services to CountyCare members.
- Sanction and Exclusion Screening is performed for all CountyCare personnel, agents, subcontractors and providers upon hire and monthly, as required by the COUNTYCARE HEALTH PLAN agreement.
- Regular oversight is exercised over subcontractors and delegated entities (also known as vendor oversight) to ensure any potential issues that are detected and reported by contractors and vendors are appropriately identified, investigated and remediated.
- Monthly FWA Workgroup meetings are responsible for reviewing Payment Integrity (PI) and Special Investigations Unit (SIU) results, taking appropriate action, and assisting the PI/SIU group in procuring relevant information.
- Monthly CountyCare Compliance Oversight Committee meetings are held to discuss new and outstanding FWA issues and to provide oversight and guidance of CountyCare operations to fulfill Compliance program requirements and monitor corrective action plans as necessary.
- Timely submission of reports regarding any suspected fraud, abuse, or financial misconduct by CountyCare members, providers, employees or contractors to the HFS OIG.
- Submission of quarterly reports outlining all instances of suspected fraud, abuse or financial misconduct to the HFS OIG.

ATTACHMENT #7

Expanding the Role of the Chief Compliance Officer

Designation of the Chief Compliance Officer

- Supports contractual obligation to define and delegate compliance responsibilities for the Health Plan.
- Comports with best practice for Board and CEO approval.
- Existing job description of the Chief Compliance and Privacy Officer job allows for incorporation of duties.

- Action: Review and Approve

TITLE:	Chief Compliance Officer		
Job Code:		Grade:	24
Reports To:	CCHHS Board of Directors and the Chief Executive Officer		

POSITION SUMMARY

Brief summary of position.

The Chief Compliance Officer is also the Chief Privacy Officer, this position reflects the mission and vision of Cook County Health & Hospitals System (CCHHS) and oversees the CCHHS Corporate Compliance Program[1], functioning as an independent and objective body that reviews and evaluates compliance issues/concerns within the organization. The position ensures the Board of Directors, senior management and workforce are in compliance with the rules and regulations of regulatory agencies, that company policies and procedures are being followed, and that behavior in the organization meets the CCHHS Standards of Conduct (Code of Ethics).

The Corporate Compliance Office exists (1) as a channel of communication to receive and direct compliance issues to appropriate CCHHS resources for investigation and resolution, and (2) as a final internal resource with which concerned parties may communicate after other formal channels and resources have been exhausted.

REPORTING STRUCTURE

The Chief Compliance Officer reports to the CCHHS Board of Directors through the Audit and Compliance Committee of the Board and the Chief Executive Officer.

RESPONSIBILITIES

Fundamental job duties for which this position is accountable.

- Provides oversight and guidance for the Board of Directors, Chief Executive Officer, and senior management on matters relating to compliance.
- Monitors and reports results of organizational compliance/ethics efforts. The Chief Compliance Officer is authorized to implement all necessary actions to ensure achievement of the objectives of an effective compliance program.
- Develops, initiates, maintains, and revises policies, procedures and practices for the general operation of CCHHS and its related activities to prevent illegal, unethical, or improper conduct.
- Guides and partners with operational leadership to facilitate operational ownership of compliance.
- Monitors organizational compliance activities of CCHHS.
- Develops and periodically reviews and updates Standards of Conduct to ensure continuing relevance in providing guidance to management and employees.
- Collaborates with operational areas throughout the organization to direct compliance issues to appropriate channels for investigation and resolution. Consults with the legal counsel as needed to resolve difficult legal compliance issues.
- Responds to alleged violations of rules, regulations, policies, procedures, and the CCHHS Standards of Conduct by evaluating or recommending the initiation of investigative procedures. Develops and oversees a system for uniform handling of such violations.
- Acts as an independent review and evaluation body to ensure that compliance issues/concerns are being appropriately evaluated, investigated and resolved.
- Identifies potential areas of compliance vulnerability and risk; develops/implements corrective action plans for resolution of problematic issues, and provides general guidance on how to avoid or deal with similar situations in the future.

[1] Section 6401 of the Affordable Care Act requires healthcare providers participating in federal healthcare programs to establish compliance and ethics programs that contain certain "core elements" as a condition of participation. The core elements can be found within the Department of Health and Human Services (HHS), Office of Inspector General published Compliance Program Guidance in 1998 and Supplemental Guidance in 2005, these documents, along with the Federal Sentencing Guidelines provide the foundation for Compliance Programs.

- Ensures proper hospital reporting of violations or potential violations to duly authorized enforcement agencies as appropriate and/or required.
- Establishes and provides direction and management of a system compliance hot line.
- Establishes and monitors a system to log and track all concerns/issues raised to Corporate Compliance.
- Institutes and maintains an effective compliance communication program for the organization, including promoting (a) use of the compliance hotline, (b) heightened awareness of ABC Hospital codes of conduct, and (c) understanding of new and existing compliance issues and related policies and procedures.
- Works with CCHHS Human Resources Department and others as appropriate to develop an effective compliance training program, including appropriate introductory training for new employees as well as ongoing training for all employees and managers.
- Monitors the performance of the Compliance Program and related activities on a continuing basis, taking appropriate steps to improve it effectiveness.
- Supervises the Corporate Compliance Department to insure department goals are met.
- Provides reports on a regular basis, and as directed or requested, to keep the Board of Directors and senior management informed of the operation and progress of compliance efforts.

EDUCATION/EXPERIENCE QUALIFICATIONS

Level of education and experience that is required for the position.

Required

- Masters Degree in Healthcare, Business, Education, or related field.
- Professional Certification: Certified in Heathcare Compliance (CHC)
- Ten (10) years experience in a healthcare organization, to include demonstrated leadership. Familiarity with operational, financial, quality assurance, and human resource procedures and regulations is necessary.
- Five+ (5+) years recent leadership experience in healthcare compliance
- Seven+ (7+) years of conducting complex healthcare compliance investigations
- Maintains a high degree of credibility, independence, integrity, confidentiality and trust. Strong communication and leadership skills are essential.
- Demonstrates sound business judgment and is supportive of the system mission and objectives. Commands respect of the senior management team, board level committees and other members of the compliance team.
- Strives to develop partnerships, teamwork and good working relationships. Maintains an open management style.
- Understands the complexities of a large, diverse, public, safety-net organization. Involves others appropriately in consultations and decisions.
- Understands the legal regulatory framework of the entity.
- Exhibits analytical skills and an understanding of operational processes and technology concepts.
- Maintains strong writing skills required to write and edit policies and procedures, issue memorandums and compile program reports.
- Exhibits exceptional presentation skills with large and small audiences.
- Able to operate successfully in a constantly changing, fast-paced environment. Demonstrates initiative, self-motivation, practical learning skills, enthusiasm, and an ability to complete multiple tasks in a timely and accurate manner.
- Software application skills – MS Office Access, Excel, PowerPoint, and Word.

Desired

- Juris Doctor (J.D.)
- Professional Certification: RHIA, RN, CPA, or CFE, Current & Active

Note:
This job description was developed through the review of multiple position descriptions published through the Heath Care Compliance Association (HCCA), a nationally recognized professional organization of healthcare compliance professionals.

ATTACHMENT #8

CountyCare Health Plan Oversight Meetings

Oversight meetings

- Fulfills our contractual requirement to manage and provide oversight for health plan operations.

- Action: None. Awareness only.

HEALTH PLAN OVERSIGHT COMMITTEE MEETING DESCRIPTION

Note: These oversight meetings fulfill MCCN requirements to have internal operational committees to manage and provide oversight for health plan operations. This document summarizes the various oversight committees.

Executive Committee

The CountyCare Executive Committee meets monthly and is comprised of CCHHS senior delegates and CountyCare leadership. The Executive Committee is responsible for providing the oversight, guidance and support to CountyCare leadership to support the achievement of agreed upon goals in a manner consistent with a provider sponsored organization and focused on improving the health status of underserved/at–risk populations in a fiscally appropriate manner. The Executive Committee will provide useful feedback to Plan leadership regarding Plan performance and promote alignment between CCHHS objectives and Plan programs.
Frequency: Monthly

CountyCare Finance Committee

The committee meets monthly and is responsible for recommending financial policies, goals, and budgets that support the mission, values, and strategic goals of CountyCare. The committee also reviews the organization's financial performance against its goals and proposes major transactions and programs to the board.
Frequency: Monthly

CountyCare Compliance Committee

This committee provides oversight of and guidance to CountyCare operations to fulfill Compliance Program requirements, which include the implementation and operation of the Compliance Program. The Compliance Committee will review CountyCare activity pursuant to Compliance Program requirements and contractual requirements. This would include reviews of, but not limited to, audits, monitoring activity, and corrective action plans. Based on these reports, the Compliance Committee will make recommendations to operations as necessary.
Frequency: Monthly

Quality Improvement Committee (QIC)

The QIC meets quarterly and promotes a system-wide approach to QI, provides oversight and direction in assessing the availability, access and appropriateness of care and services delivered and continuously enhances and improves the quality of care and services provided to members. This is accomplished through a comprehensive system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems; the identification of opportunities to improve member outcomes; and the education of members, providers and staff regarding the Quality Assessment and Performance Improvement (QAPI) Program.
Frequency: Quarterly

Committee Reporting to the QIC

Utilization Management (UM) Committee

The UMC's primary purpose is to provide oversight of the utilization management program, care coordination/case management program and associated activities to ensure that UM activities are integrated into all functional areas and departments. The UMC meets at least quarterly and is responsible for the analysis of UM data (such as hospital admission, ambulatory encounters, and the level of care utilized), care coordination/case management data (such as completion rates of HRS/HRA, number of enrollees in care coordination by risk level and by disease process), the identification of trends, and the addressing of identified issues. Additional responsibilities include the monitoring of the appropriateness of care, over- and under-utilization of services, review and approval of medical necessity criteria.
Frequency: Quarterly

Committee Reporting to the QIC (continued)

Pharmacy & Therapeutic Committee

The P&T Committee meets quarterly and will have oversight of and operating authority over the health plan's Pharmacy Program. The Committee will be responsible for the development and annual review of the Pharmacy Program Description and associated policies, as well as activities such as reviewing pharmacy utilization; specific Drug Utilization Review studies, particularly on the poly-pharmacy risks of SSI Enrollees; and drug interaction reports.
Frequency: Quarterly

Peer Review Committee

The Peer Review Committee (PRC) is an ad hoc committee of the QIC and is responsible for reviewing inappropriate or aberrant service by a provider including alleged quality of care concerns, adverse events, and sentinel events where initial investigation indicates a significant potential or significant, severe adverse outcome has occurred or other cases as deemed appropriate. The PRC is expected to use their clinical judgment in assessing the appropriateness of clinical care and recommending a corrective action plan that will best suit the particular provider's situation.
Frequency: Meets on an *ad hoc* basis

Physician Advisory Committee

The Committee will be held to communicate CountyCare's programs and processes to its provider network. The Committee provides input on the health plan's Provider profile and incentive programs, and other administrative practices, and supports development of the physician scorecard indicators, useful analyses of the data, and effective means of helping Providers improve their performance.
Frequency: Meets on an *ad hoc* basis

Credentialing Committee

The Credentialing Committee shall ensure network providers, facilities and practitioners are qualified, properly credentialed and available for access by plan members. The CC has the responsibility for credentialing and re-credentialing physicians, non-physician practitioners, facilities, long-term care providers, and other practitioners in the plan network and to oversee the credentialing process to ensure its compliance with regulatory and accreditation requirements.
Frequency: Six (6) times per year

Performance Improvement Team

Performance Improvement Team (PIT) is an internal, cross-functional quality improvement team that facilitates the integration of a culture of quality improvement throughout the organization. The PIT is responsible for gathering and analyzing performance measures, performing barrier and root cause analysis for indicators falling below desired performance and making recommendations regarding corrective actions/ interventions for improvement. The PIT is also responsible for overseeing the implementation of recommended corrective actions/interventions from the QIC and/or its supporting subcommittees, monitoring the outcomes of those improvement efforts and reporting back to the designated committee. Multiple PITs may exist.
Frequency: Ad hoc initially, then schedule will be developed

Enrollee Advisory and Community Stakeholder Committee

The Enrollee Advisory and Community Stakeholder Committee meets on a quarterly basis to provide feedback to the QIC on health plan's performance from Enrollee and community perspectives; recommends program enhancements based on Enrollee and community needs; identifies key program issues, such as disparities, that may impact community groups; provides input on service improvements; and offers guidance on effective approaches for reaching Enrollees or other Enrollee-related issues. These committees review Enrollee and Provider satisfaction survey results; evaluates performance levels and telephone response times; reviews Enrollee educational materials for relevance, understanding and ease of use; evaluates network access issues; and provides feedback as requested by the QAPI.
Frequency: Quarterly

Committee Reporting Jointly to the Compliance Committee and the QIC

Delegated Vendor Oversight Committee

The Committee meets monthly to provide oversight of the operations affecting the scope of functions of delegated vendors and subcontractors to ensure compliance with statutory and contractual requirements, including Key Performance Indicators. The Committee also provides oversight of quarterly delegation oversight audits, monthly joint operations meetings and regular monitoring of enrollee and provider complaints.

Frequency: Monthly

Grievances and Appeals Committee

The Grievance and Appeals Committee (GAC) is responsible for monitoring Member grievances and appeals including those arising from delegated vendors and subcontractors. Tracking and analysis of all grievances and appeals to assess the trends and patterns in addition to the timeliness of resolution, performing barrier and root cause analysis and making recommendations regarding corrective actions, as indicated.

Frequency: Monthly

Committee Reporting to the Compliance Committee

Fraud Waste and Abuse Committee

Monthly Workgroup meetings are responsible for reviewing Payment Integrity (PI) and Special Investigations Unit (SIU) activities, taking appropriate action, and assisting the PI/SIU group in procuring relevant information.

Frequency: Monthly

Policy Committee

Quarterly Workgroup to ensure all CountyCare policies are reviewed on an annual basis.

Frequency: Quarterly

ATTACHMENT #9

CountyCare Compliance Steering Committee Charter

The Charter

- Fulfills contractual requirements that compel the development of a Compliance Committee to oversee the health plan's Fraud Waste and Abuse Plan and operations.
- This document outlines the charter statement for the committee, the various inputs that will be considered by the committee, the communications and reports generated by the committee, as well as the voting rights for committee members.
- The CountyCare Corporate Compliance Committee is chaired by the CCHHS Compliance and Privacy Officer and meets on a monthly basis and contains membership from both CCHHS leadership, CountyCare leadership, IlliniCare (TPA) compliance and operations.

- Action: Receive and File

CountyCare Compliance Steering Committee Charter

Chair: CCHHS Chief Compliance Officer
Reports to: CCHHS Board of Directors through the Audit and Compliance Committee
Frequency: Monthly
Implemented: 08/21/2014
Last reviewed/ revised: as above

Charter Statement: To provide oversight and guidance of CountyCare operations to fulfill Compliance program requirements and monitor corrective action plans as necessary.

Inputs to the Compliance Committee:

- Compliance Plan 2014
- Fraud, Waste and Abuse (FWA) Reports
  - Hotline Reports
  - Investigations
    - SIU Report
- Reports/Audits
  - Grievances and Appeals Reports
  - Sanction Screening Reports
  - Conflict of Interest Reports
  - Delegated Vendor Oversight & Audits
  - Upcoming Audits
- Training Reports
  - FWA
  - HIPAA
  - Cultural Competency
  - Health, Safety and Welfare
  - Provider Education
- Policy and Procedures
  - Development/Review
  - Audits
- HIPAA Updates
- Quality Improvement Plans – Current/Status
- Corrective Action Plans – Current/Status
- Identification of New Organizational Risks

Communications

- Recommendations/Corrective Actions

Key audiences:

- Executive Oversight Committee
- CCHHS Board of Directors through the Audit and Compliance Committee
- Plan Administration

Voting:
All members, including the chair, have one vote. In the event a member is not present, they can send an alternate on their behalf. The alternate can cast the vote for the member. At least 50% of the voting members, or their delegates, must be present for quorum. Any vote must be approved by at least 2/3.

Reporting:
The main reporting tool from the Compliance Committee is the Meeting Minutes. A summary of the meeting will be provided to the CCHHS Board of Directors through the Audit and Compliance Committee.

CountyCare Fraud, Waste and Abuse Program

The Program

- Monitors the Health Plan's Fraud, Waste and Abuse (FWA) Program with goal of protecting consumers in the delivery of healthcare services through timely detection, investigation and prosecution of FWA.
- Achieves goal by establishing:
  - Training programs for CountyCare employees, vendors, subcontractors, about their role in the FWA process.
  - Defining methods to identify, prevent, review and initiate corrective actions against any provider or member who is suspected of participating in FWA activities.
  - Developing policies and procedures.
  - Outlining the workflow to be followed in the event that a potential FWA issue or overpayment is identified.
  - Reporting identified FWA issues, including referral to state and local authorities.
- Oversees all FWA activities performed by Health Plan's delegated vendors.

	CountyCare Fraud, Waste and Abuse Workgroup Date: Time: Place: Dial in #: Leader: Ryan Lipinski, CountyCare Compliance Officer
Meeting Purpose:	Monthly Workgroup meetings are responsible for reviewing Fraud, Waste and Abuse Programs of delegated vendors. This meeting will include Payment Integrity (PI) and Special Investigations Unit (SIU) activities, taking appropriate action, and assisting the PI/SIU groups in procuring relevant information.

Primary Attendees:

Members	Staff	Other
CCHHS	TPA	CC OIG
CountyCare	Other Delegated Vendors	

Sample Agenda Topics

Review of Delegated Vendors Fraud Waste and Abuse (FWA) Policies and Procedure

Dashboard Statistics Development

2015 FWA Work Plan

Report Review

- PI/SIU Report Review

Status of Open Investigations

- Investigation Name
- Referral Type
- Referral Source
- Investigation Phase/Status
- Preliminary Review Finding and Recommendation
- Final Report Generated (Y/N)
- Recommended Action Taken

Referrals made to and/or received from HFS OIG

FWA Program Updates

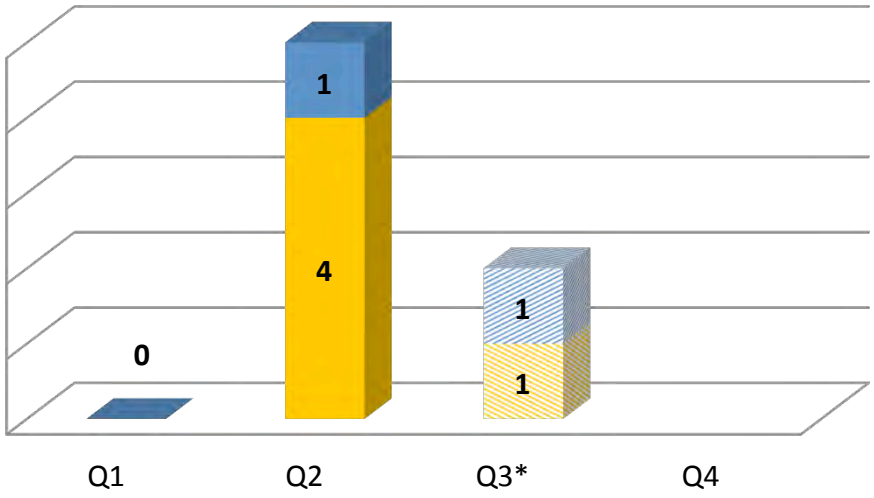
- New staffing changes or program oversight responsibilities
- New regulations or guidance impacting FWA subject area
- Employee training or professional development associated with FWA operations (e.g., conferences, webinars attended)

FWA – Open Items

FWA Activity

State Fiscal Year

July 2014 – June 2015



Q3* = only 1-month of data (January)
Note: HFS requires quarterly reporting using the State Fiscal Year

Seven (7) cases identified to date:

- Four (4) Providers
  - Potential upcoding on two (2)
  - Potential "boiler plate" coding on one (1)
  - One (1) provider misidentified as CountyCare (case closed)
- Two (2) Ambulance Providers
  - Potential upcoding
- One (1) Member
  - Allegation of ineligibility (transitioned to HFS OIG – closed)

ATTACHMENT #10

CountyCare Grievances and Appeals Process

The Process

- Provides a mechanism for members to file complaints and a way for members or providers to file appeals when a request for a medical item or service is denied by CountyCare.
- Allows for tracking of grievances and appeals by category, volume and resolution.
- Contributes to identify program improvement opportunities, which may reduce the issues that give rise to grievances and appeals.
- Represents a primary mechanism for CCHHS Corporate Compliance and CountyCare operations to exercise oversight of the TPA and other vendor operations with respect to grievances and appeals.

- Action: Receive and File

GRIEVANCES AND APPEALS DEFINITIONS

Contractor shall submit a summary of the Grievances and Appeals filed by Enrollees, organized by categories of as defined below. The report shall include a summary count of any such Grievances or Appeals received during the reporting period including those that go through fair hearings and external independent reviews. The report shall include Appeals and Grievances outcomes and the levels at which the Grievances or Appeals were resolved and whether the appeals were upheld or overturned. Contractor shall provide this report for each population for which it provides Covered Services. ***Reporting Frequency: Quarterly***

Section	Term	Definition
Types	**Grievance**	The expression of dissatisfaction by a Member including complaints and requests for disenrollment, about any matter other than a matter that is properly the subject of an appeal.
	Appeal	A request for review of a decision made by CountyCare with respect to an action. An action is defined as the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the State; the failure to act within the set timeframes.
	Expedited Appeal	An appeal filed when taking the time for a standard (appeal) resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function.
	External Independent Review	Except for denial or Waiver services, which may not be reviewed by an external independent entity, the Enrollee may request an external independent review, both standard and expedited timeframes, of appeals that are denied by Contractor within thirty (30) calendar days after the date of the Contractor's decision notice [HFS].
	Fair Hearing	The State plan must provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly. Final decisions of Appeals not resolved wholly in favor of the Enrollee may be appealed by the Enrollee to the State under its Fair Hearings system within thirty (30) calendar days after the date of the Contractor's Decision Notice.
Section	**Term**	**Definition**
Categories	**Medical Necessity**	Determinations on decisions that are or which could be considered covered benefits. This includes determinations for covered medical benefits as defined by the organization, including hospitalization and emergency services listed in the Certificate of Coverage or Summary of Benefits and care of service that could be considered either covered or non-covered, depending on the circumstances.
	Access to Care	Areas of concerns such as: cannot find Provider, inconvenient hours, Provider capacity, out of area Providers, refusal to take Medicaid, ADA non-compliance, unable to address language needs, not meeting appointment times requirements.
	Quality of Care	The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.
	Transportation	Any grievance or appeal relating to the transportation benefits.
	Pharmacy	Any grievance or appeal relating to the pharmacy benefits.
	HCBS Waiver Services	*Grievance:* Any expression of dissatisfaction relating to HCBS Waiver Services. *Appeal:* Any appeal related to the reduction, elimination, or timeliness of services or hours through the Community Care Program or the Home Services Program.
	Long Term Care (LTC) Services	*Grievance:* Any expression of dissatisfaction relating to LTC Services. *Appeal:* Any appeal related to the reduction, elimination, or timeliness of services or hours through the Community Care Program or the Home Services Program.
	Other	Any kind of grievance or appeal not covered by the previously mentioned topics.

GRIEVANCE AND APPEALS SUMMARY
July 2014 – September 2014
Q1 , SFY 2015

Grievances and Appeals Received									
Category	Medical Necessity	Access to Care	Quality of Care	Transportation	Pharmacy	HCBS Waiver Services	LTC Services	Other	Total
Grievances	-	12	41	1	1	-	-	1	56
Appeals	-	-	-	-	4	-	-	-	4
Expedited Appeals	-	-	-	-	-	-	-	-	-
Total	-	12	41	1	5	-	-	1	60

Grievances and Appeals Resolved									
Category	Medical Necessity	Access to Care	Quality of Care	Transportation	Pharmacy	HCBS Waiver Services	LTC Services	Other	Total
Grievances	-	9	39	-	-	-	-	-	48
Appeals	-	-	-	-	2	-	-	-	2
Expedited Appeals	-	-	-	-	16	-	-	-	-
Total	-	-	39	-	18	-	-	-	50

Grievances Outcomes			
Category	Total # of Grievances Resolved	# of Grievances Resolved within 90 Days	% of Grievances Resolved within 90 Days
Grievances Resolved	48	48	100%

Appeals Outcomes				
Category	Upheld	Overturned	# of Appeals Resolved within 15 Business Days	% of Appeals Resolved within 15 Business Days
Appeals Upheld/Overturned at MCO Level	1	1	2	100%
Total	1	1		

Expedited Appeals Outcomes				
Category	Upheld	Overturned	# of Expedited Appeals Resolved within 24 Hours	% of Expedited Appeals Resolved within 24 Hours
Expedited Appeals Upheld/Overturned at MCO Level	-	-	-	N/A
Total	-	-		

GRIEVANCE AND APPEALS SUMMARY
October 2014 - December 2014
Q2 , SFY 2015

Grievances and Appeals Received

Category	Medical Necessity	Access to Care	Quality of Care	Transportation	Pharmacy	HCBS Waiver Services	LTC Services	Other	Total
Grievances	-	4	33	5	-	-	-	13	55
Appeals	15	-	-	-	32	-	-	-	47
Expedited Appeals	-	-	-	-	16	-	-	-	16
Total	15	4	33	5	48	-	-	13	118

Grievances and Appeals Resolved

Category	Medical Necessity	Access to Care	Quality of Care	Transportation	Pharmacy	HCBS Waiver Services	LTC Services	Other	Total
Grievances	-	3	10	-	-	-	-	5	18
Appeals	10	-	-	-	29	-	-	-	39
Expedited Appeals	-	-	-	-	16	-	-	-	16
Total	10	3	10	-	45	-	-	5	73

Grievances Outcomes

Category	Total # of Grievances Resolved	# of Grievances Resolved within 90 Days	% of Grievances Resolved within 90 Days
Grievances Resolved	18	18	100%

Appeals Outcomes

Category	Upheld	Overturned	# of Appeals Resolved within 15 Business Days	% of Appeals Resolved within 15 Business Days
Appeals Upheld/Overturned at MCO Level	-	10	10	100%
Total	-	10		

Expedited Appeals Outcomes

Category	Upheld	Overturned	# of Expedited Appeals Resolved within 24 Hours	% of Expedited Appeals Resolved within 24 Hours
Expedited Appeals Upheld/Overturned at MCO Level	3	13	7	43.75%
Total	3	13		

ATTACHMENT #11

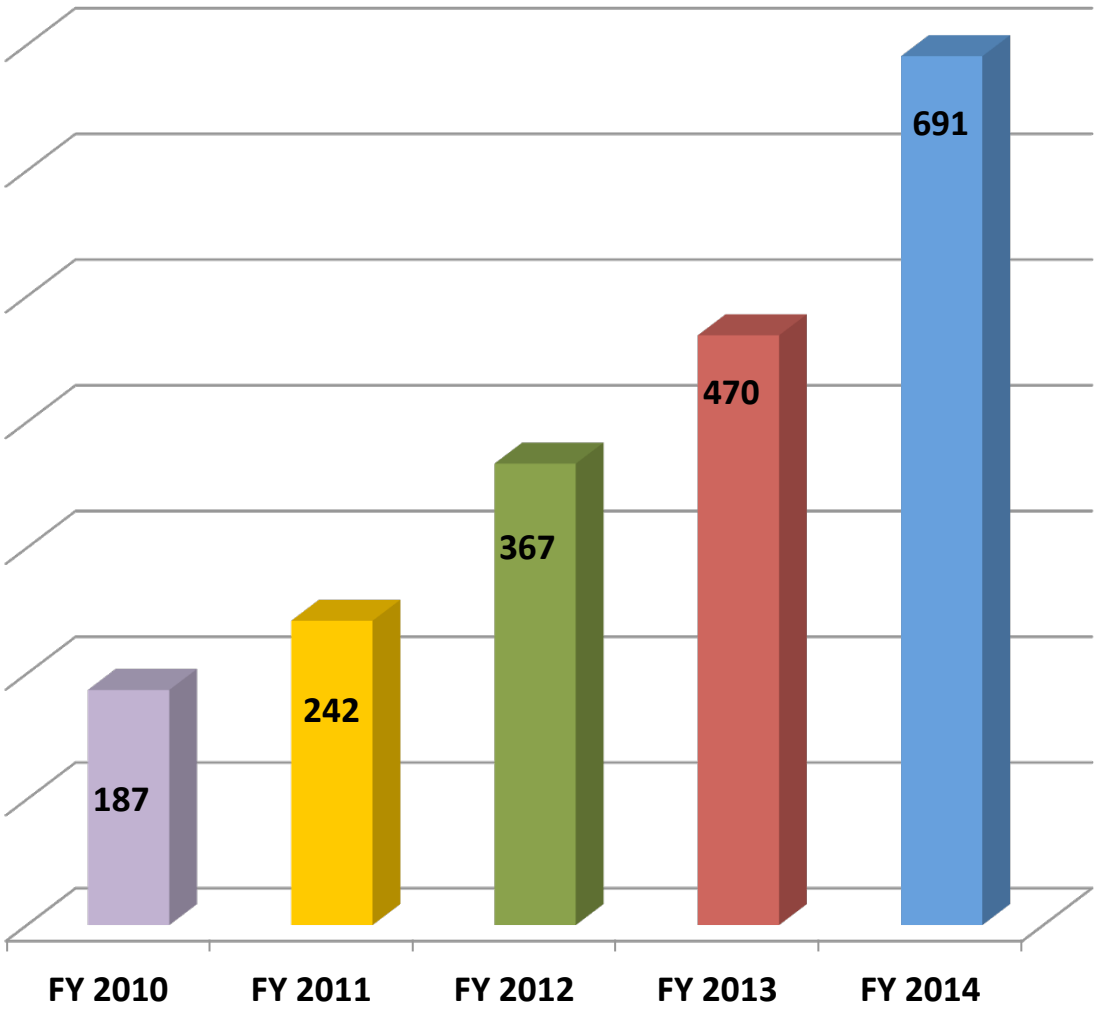
Fiscal Year End Report

This Report

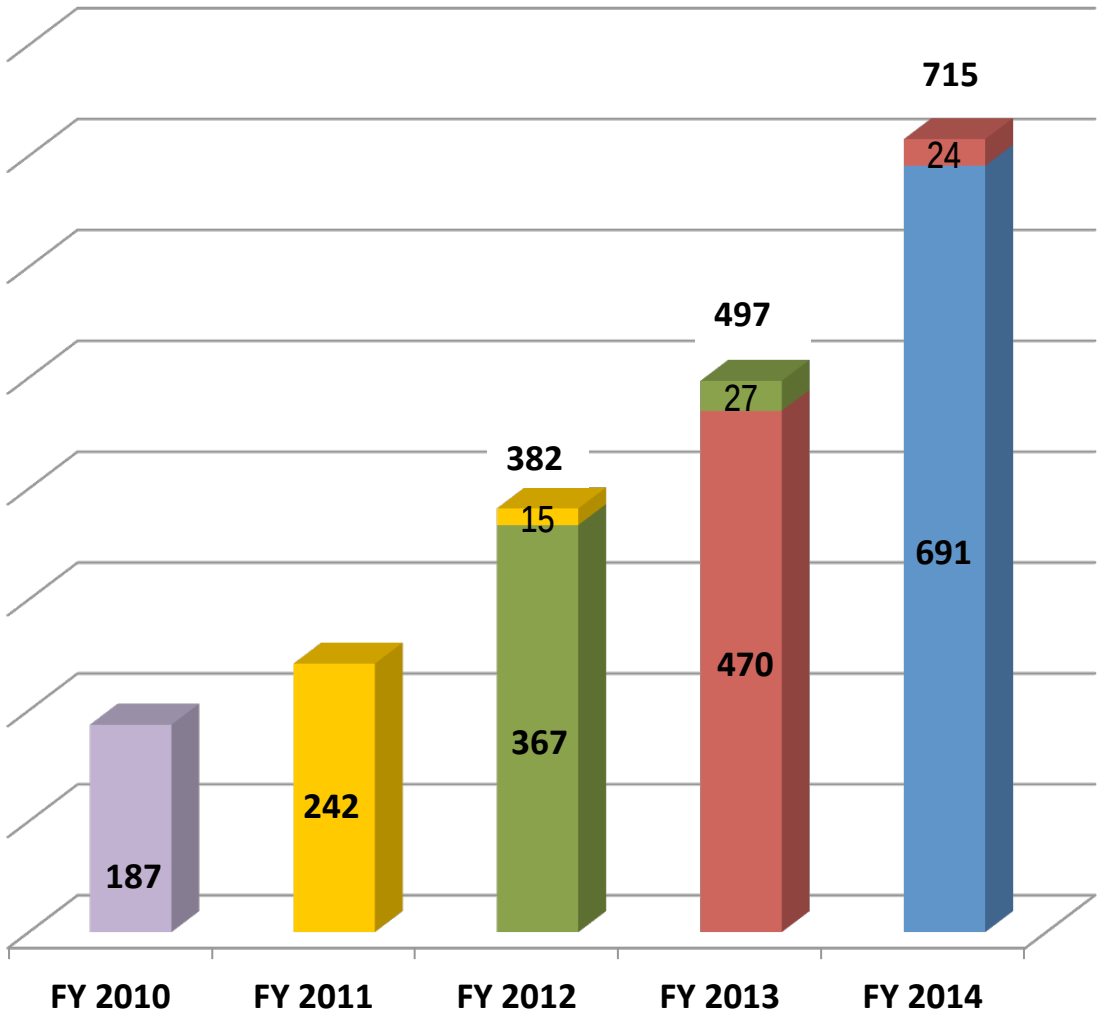
- Summarizes FY 2014 Corporate Compliance activity.
  - Reactive activity volumes
  - Completed projects (pro-active activity)

- Action: Receive and File

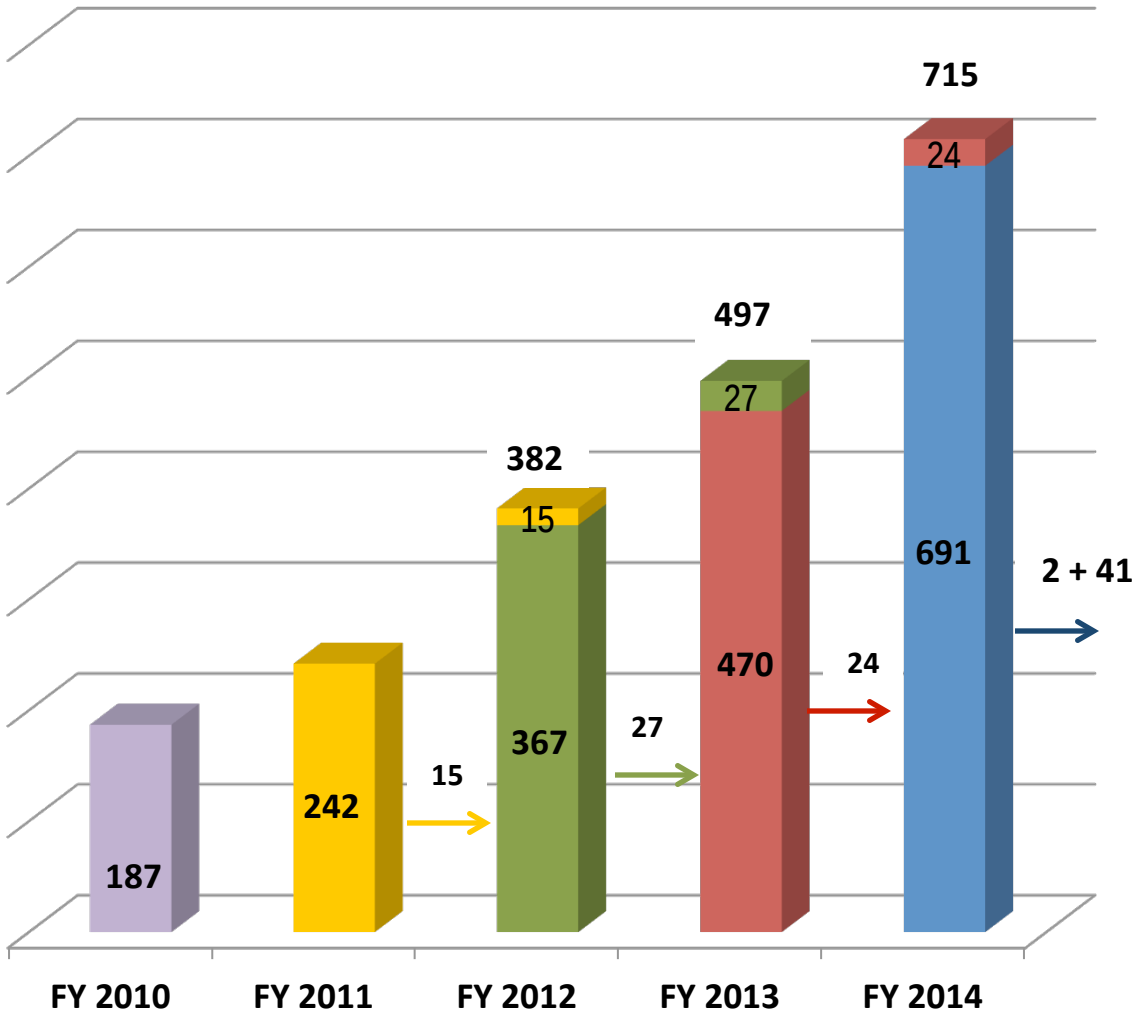
Reactive Issue Count by Fiscal Year



Actual Reactive Issue Activity

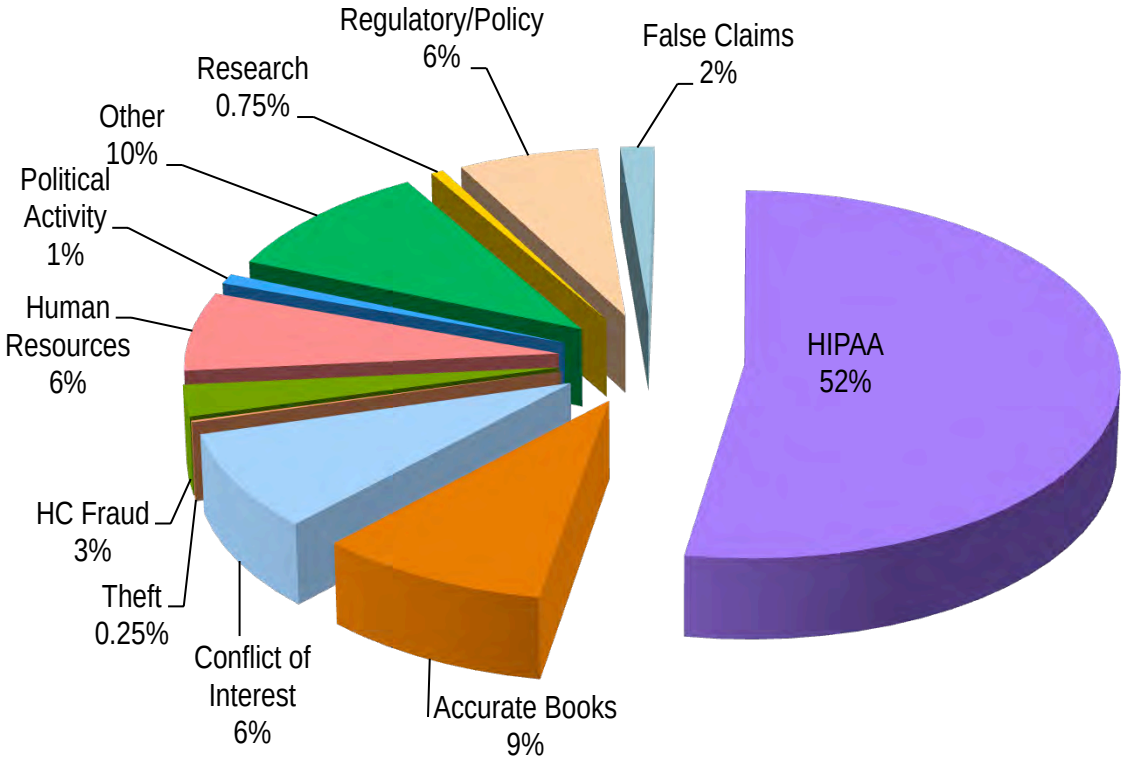


Actual Reactive Issue Activity



2014 Issue Breakdown by Category

671[1] Reactive Corporate Compliance Issues Were Raised



Category Count[1]

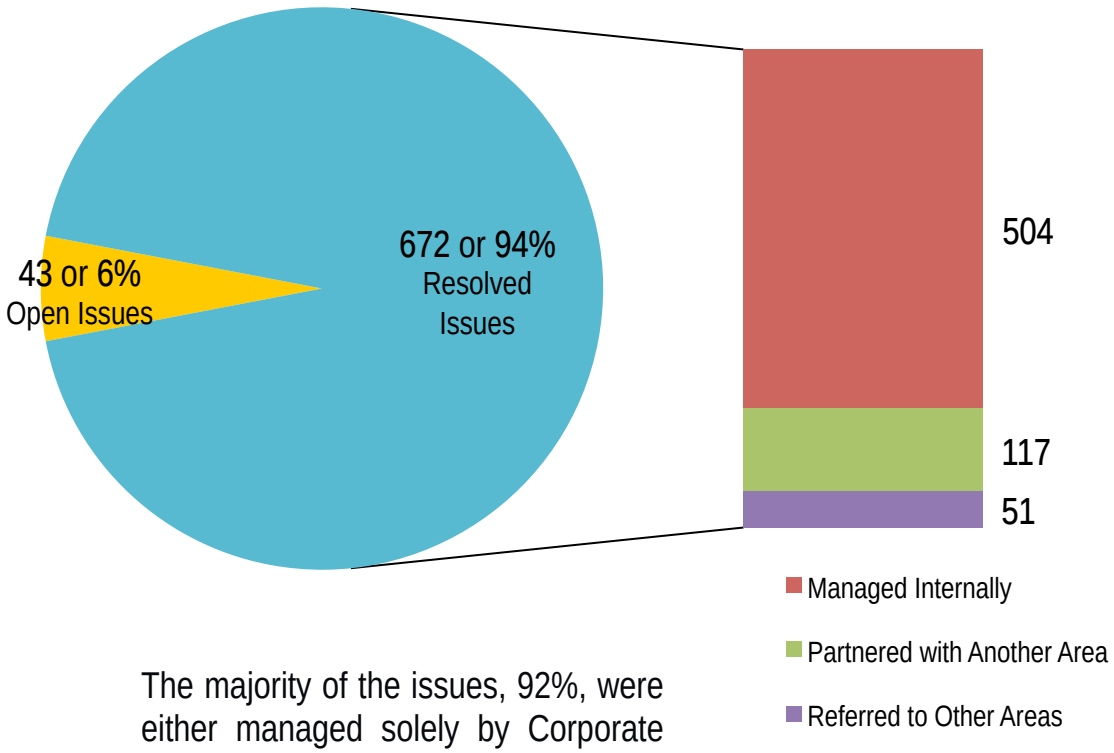
Privacy (HIPAA)	362	Human Resources	48	Political Activity	6	Regulatory/Policy	45
Accurate Books	65	HC Fraud	19	Research	4	Other	71
Conflict of Interest	59	False Claims	11	Theft	1		

[1] This is a total count of the issues raised to Corporate Compliance. Not all issues are validated/substantiated.

COOK COUNTY HEALTH & HOSPITALS SYSTEM CCHHS

Status Report of Issues

Of the total number of reactive issues addressed during FY 2014, 6% or 43 issues remained open at close of the fiscal year.



The majority of the issues, 92%, were either managed solely by Corporate Compliance or Corporate Compliance partnered with another area to address the concern raised.

FY 2014 Projects

- CountyCare
  - Established a Corporate Compliance Program to demonstrate commitment to promoting ethical and lawful conduct consistent with all applicable laws, regulations, and contractual requirements, as well as CCHHS policies, procedures, and Code of Ethics/ Standards of Conduct.
  - Developed Compliance Plan.
- 340B Compliance
  - Partnered with operational areas to develop policy and corresponding procedures to document compliance.
- External DRG Probe Audit
  - Reviewed a random sample of the top DRG's at both John H. Stroger Jr. Hospital and Provident Hospital. Deficiencies noted, coders reeducated, and corrective action plan includes ongoing monitoring.
- Teaching Physician Attestation with Primary Care Exception
  - Assessed current process and researched Medicare Requirements. Facilitated meetings with Physician Leadership, created Policies and Procedures, and assisted in implementation.
- Identity Theft
  - Partnered with operations to create policies and procedures; developed a consistent approach to remedy the impact of identity theft on operations.

Projects *(continued)*

- Medical Records
  - Assisted with policies and procedures for release of information and amending medical records. Updated release of information authorization forms.
- Record Retention
  - Developed retention matrix, which will supplement the existing policy and provide retention guidance to the System using the Illinois Hospital Association's Record Retention Reference and the current retention material filed with the state of Illinois.
- Education
  - Developed compliance focused modules for annual education for the CCHHS workforce.
  - Managed the ongoing operations and day-to-day management of the CCHHS electronic learning management system (LMS) for all organizational training.
- Conflict of Interest
  - For all employees: Developed a Dual Employment eForm.
  - For those with decision-making responsibilities: Accounting of Disclosures.
  - Managed Processes for both.